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STRONG FAMILIES *THRIVING* CHILDREN

2019

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In the past few years, people have come to realize that family and child well-being are public health issues. Helping families and children be happy, healthy and resilient helps the larger community. This report will discuss various aspects of family life including the systems that exist to support them, ways families can have more positive experiences, and some of the struggles families face that compromise their life experiences.

Why Should We Care Whether Families Are Happy, Healthy, and Resilient?

Families are the building blocks of a society, they are the foundational social unit in all communities and societies throughout the world. A family is the first organization a human encounters and is the first place a human receives education, protection and advocacy for basic human survival.

There are significant costs to society when children and families don't thrive. On average, the estimated lifetime cost of child maltreatment is about $210,000 for each victim. This cost includes childhood health care costs, adult health care costs and lost productivity, among others.[1]

What Can the Community Do to Help Families Be Happy, Healthy, and Resilient?

The community has a large role to play in supporting families. Individuals, churches, non-profits, government agencies, foundations, and businesses all can contribute to helping families thrive. Some of the best ways to help families are by engaging in activities that increase the protective factors and capacity of families.

Protective factors are characteristics or strengths of individuals, families, or communities that help reduce risks and negative effects of traumatic or difficult situations.[2] The protective factors framework was developed by the Center for the Study of Social Policy. They conducted research including literature reviews and discussion groups with experts to identify which factors had the most impact on improving family well-being and reducing the likelihood of child abuse and neglect.[3]

The protective factors are:

- **Parental resilience** – Ability to manage stress and maintain functioning when confronted with challenges or trauma.

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[1] Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). *The Economic Burden of Child Maltreatment in the United States and Implications for Prevention*. Child Abuse and Neglect, 36, 156-165.
[2] Center for the Study of Social Policy. (n.d.). *About Strengthening Families and the Protective Factors Framework*. Retrieved from: https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf
[3] Ibid.

- **Social connections –** Relationships with others that provide individuals with emotional support, friendship and advice.
- **Knowledge of parenting and child development –** Basic understanding of child development including knowing what childrens' needs are at different developmental stages and having appropriate expectations for children. Knowledge of parenting includes understanding the important protective role of a parent and also knowing where to turn for help and informational resources.
- **Concrete support in times of need –** Access to concrete supports in times of need such as monetary assistance, emergency child care assistance or transportation.
- **Social and emotional competence of children –** Child's ability to interact in a positive way with others, communicate feelings and self-regulate behavior.

Protective factors also help to reduce the effects of Adverse Childhood Experiences (ACEs). A study conducted by the Centers for Disease Control and Kaiser Permanente found that traumatic experiences as a child can negatively impact one's health as an adult and even lead to costly health care and early death.[4]

Getting to Know Arizona Families and the Current State of Affairs

Here are a few facts to provide a snapshot of Arizona's families:

- According to the 2018 Kids Count profile compiled by the Annie E. Casey Foundation, 24 percent of Arizona Children are in poverty compared to 19 percent of children at the national level.[5]
- According to Child Trends, the national average of children in foster care is 6 per 1,000 children.[6] In Arizona, the rate is 10 per 1,000 children.[7]
- According to the National Center for Education Statistics, Arizona's graduation rate for public high school students was 80 percent, which is less than the US national average at 84 percent.[8]

The chapter on child well-being (pages 3-10) will present more detailed information about the trends of child and family well-being over time in Arizona.

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[4] Centers for Disease Control and Prevention. (2016). *About the CDC-Kaiser ACE Study*. Retrieved from: https://www.cdc.gov/violenceprevention/acestudy/about.html

[5] The Annie E. Casey Foundation. (2018, June 27). *2018 Kids Count Data Book: State Trends in Child Well Being*. Retrieved from: https://www.aecf.org/resources/2018-kids-count-data-book/#state-rankings

[6] The Annie E. Casey Foundation. (2018). *Kids Count Data Center: Children 0 to 17 in Foster Care*. Retrieved from: https://datacenter.kidscount.org/data/tables/6242-children-0-to-17-in-foster-care#detailed/1/any/false/870,573,869,36,868,867,133,38,35,18/any/12985,12986

[7] Ibid.

[8] National Center for Education Statistics. (May, 2018). *Public High School Graduation Rates*. Retrieved from: https://ncesed.gov/programs/coe/indicator_coi.asp

CHILD WELL-BEING

By Judy Krysik, MSW, PhD
Director, ASU Center for Child Well-Being

This chapter examines trends in select indicators of child well-being across four domains: economic, health, education and safety. First, demographic characteristics of Arizona children are presented to place the outcomes in context. Where possible, this chapter draws comparisons between the well-being of Arizona children and children nationally.

Families today do differ from those of earlier decades. The development of collective social insurance programs diminished the need for large families whose role it was to care for aging parents.[1] Today, women are in the work force in significant numbers, and their earnings account for an important part, if not majority or totality, of the family's income. In the past, women had fewer opportunities for careers outside the home.

Over time, reductions in infant mortality have led to fewer pregnancies and births. Access to methods of fertility control have allowed women to delay or avoid pregnancy altogether. Not surprisingly, in the face of these trends, we have seen sharp declines in birth rates and smaller family sizes. Most women are no longer occupied by extended periods of child bearing. Child rearing is more evenly divided by the adults in the home than in the past. Grandparents and other elderly relatives are being cared for at the same time as children, and adult children are more likely to return to their parents' homes in times of need than in the past, leading to new terms to describe the family such as the "sandwich generation" and "boomerang" children.

Child Demographics

Understanding the demographics of Arizona children is important for planning. The number of children in the state determines the demand and funding for schools, health care, and other social programs.

In 1990, the child population in Arizona, i.e., individuals less than 18 years of age, reached one million. The number of children steadily increased thereafter until the economic recession of 2008. Post 2008, the population of children in Arizona declined until 2014. By 2017, the child population was estimated at 1,633,490; the first post-recession year that it exceeded the 2008 estimate. Figure 1 shows the most recent 27-year trend in the Arizona child population.

Birth Rate

In recent post-recession years, Arizona experienced the greatest birth rate decline in the nation. The birth

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[1] Moroney, R., & Krysik, J. (1998). *Social Policy and Social Work: Critical Essays on the Welfare State*. New York: Aldine de Gruyter.

Figure 1. Arizona Child Population.

Children less than 18
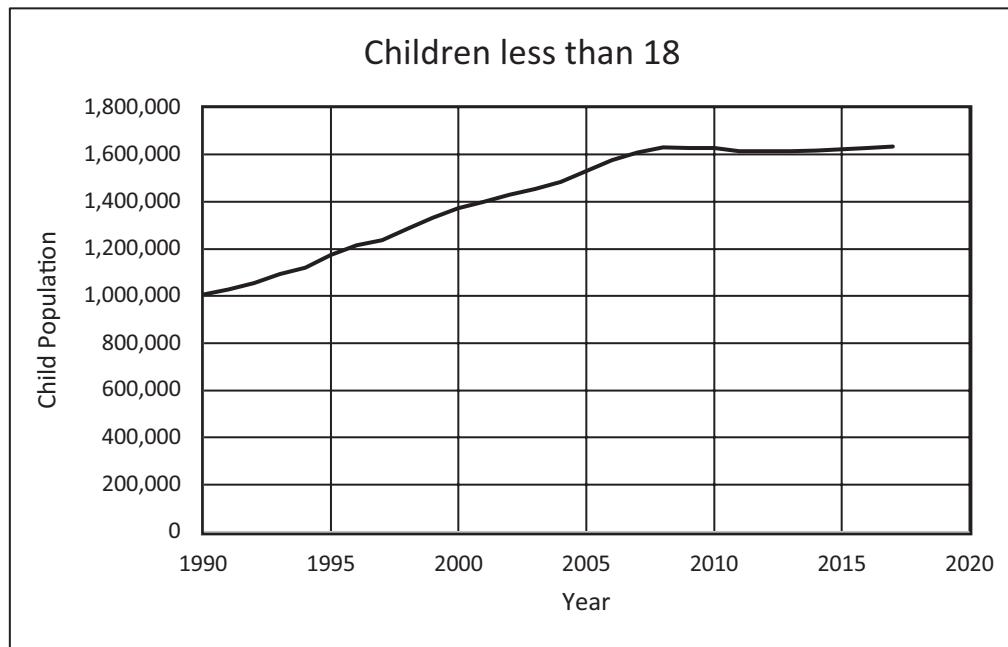
Data Source: *Population Division, U.S. Census Bureau. Updated August 2018. Data presented for 2010 through 2017 are vintage 2017 population estimates. Each year the U.S. Census Bureau revises their post-2010 estimates. Therefore, data presented here may differ from previously published estimates. Figures for 1990, 2000, and 2010 represent revised population estimates for July 1, 1990, July 1, 2000, and July 1, 2010 - not actual Census counts from April 1, 1990, April 1, 2000, and April 1, 2010.*

rate fell sharply from 16.4 per 1,000 population in 2006 to 13.0 per 1,000 in 2014.[2] This difference has resulted in approximately 20,000 fewer births per year. For example, in 2007 there were 102,687 births compared to approximately 81,000 in 2017.[3]

Several factors have contributed to the decline in birth rate, however, one positive trend is a lower teen pregnancy rate. Teen pregnancies decreased by 55.3 percent from 15,038 in 2007 to 6,724 in 2016. The teen pregnancy rate declined from 34.4 pregnancies per 1,000 girls 10-19 years of age in 2007, to 14.9 per 1,000 in 2016. That year, the number of teenage pregnancies and the teen pregnancy rate in Arizona were the lowest on record since 1980. Still, however, Arizona exceeded the national rate of 9.0 per 1,000 births to teen mothers in 2016.[4] Teen pregnancies are of concern as babies born to teen mothers are more likely to be born preterm and low birthweight, and are more likely to live in poverty, which creates other forms of disadvantage described later in this chapter.[5]

Race and Ethnicity

The race and ethnic composition of Arizona's child population provides important context for understanding the state's future. The percentages presented in Table 1 paint a picture of increasing diversity in the Arizona child population. Hispanic children have surpassed white, non-Hispanic children as the largest ethnic category since 2010. The proportion of white, non-Hispanic children continues to

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[2] Arizona Department of Health Services. (n.d.). Table 5B-2. Birth rates by county of residence, Arizona, 2006-2016. Retrieved from: https://pub.azdhs.gov/health-stats/menu/info/trend/index.php?pg=births
[3] Ibid.
[4] Federal Interagency Forum on Child and Family Statistics. *America's Children: Key National Indicators of Well-being,* 2018. Washington, DC: U.S. Government Printing Office.
[5] Annie E. Casey, 2018.

fall over time from 43 percent in 2008 to 39 percent in 2017, whereas all other groups including mixed race children represented in Table 1 have increased. This change in racial and ethnic composition points to areas of concern as the following sections on economic, health, education and safety indicators demonstrate, non-white children tend to be overrepresented on a number of risk factors.

Table 1. Percentage Distribution of Arizona Child Population Less than 18 Years by Race

Race/Year N	2008 1,628,651	2010 1,626,112	2012 1,613,477	2014 1,617,569	2016 1,628,054	2017 1,633,490
White alone [1]	43%	42%	41%	40%	40%	39%
Hispanic	42%	43%	43%	44%	44%	44%
Black alone [1]	4%	4%	4%	4%	5%	5%
Asian alone [1]	2%	2%	2%	3%	3%	3%
Two or more [1]	3%	3%	3%	4%	4%	4%
Other [1,2]	6%	6%	7%	5%	4%	5%

[1] Not Hispanic.
[2] "Other" includes Native Hawaiian and Pacific Islander as well as American Indian.
Data Source: *Population Division, U.S. Census Bureau. Data presented for 2010 through 2017 are Vintage 2017 population estimates. Each year the U.S. Census Bureau revises their post-2010 estimates. Therefore, data presented here may differ from previously published estimates. Figures for 2010 represent revised population estimates for July 1, 2010 - not actual Census counts from April 1, 2010.*

Economic Well-Being

The well-being of children depends in part on the economic circumstances of their families. Table 2 shows the percentage of all Arizona children living in poverty, i.e., families with incomes below 100 percent of the poverty threshold. Although poverty has declined over the five-year period, child poverty in Arizona was three-to-five percentage points higher than the national average in each year presented.

The likelihood of a child living in poverty varies significantly by race. Also seen in Table 2, white children and children of Asian/Pacific Islander descent are much less likely to be living in poverty in Arizona than American Indian, black or Hispanic children. The percentage of children living in poverty decreased from 2016 to 2017 for all racial/ethnic groups, with the exception of American Indian children who comparatively

Table 2. Percentage Distribution of Children in Poverty by Race and Ethnicity

		2013	2014	2015	2016	2017
Arizona	American Indian	47%	46%	46%	41%	45%
	Asian/Pacific Islander	18%	13%	11%	14%	8%
	Black	30%	35%	30%	31%	28%
	Hispanic	37%	35%	35%	32%	27%
	Non-Hispanic White	14%	13%	12%	13%	11%
	All Races	26%	26%	25%	24%	21%
US	All Races	22%	22%	21%	19%	18%

Data Source: *Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2017 American Community Survey. These percentages were derived from American Fact Finder table C17001 (B,C,D,E,H,I)(factfinder2.census.gov/).*

have exceptionally high poverty rates. Poverty makes children vulnerable to poor health, education and safety risks. In contrast to their peers, children living in poverty, especially young children, are more likely to have cognitive, behavioral, and socioemotional difficulties.[6]

Health

Children's health is fundamental to their overall development. The concern for children's health begins prior to birth and includes the mother's nutrition and mental health, as well as her exposure to social conditions such as domestic violence and access to health care. This section examines four indicators of child health.

Low Birthweight

Low birthweight is defined as a child who is born weighing less than 2,500 grams, or 5.5 pounds. Babies born at a low birth weight are more susceptible to developmental delays and disabilities. Despite Arizona's decline in birthrate, the percentage of low birthweight babies has held constant from 2006 to 2015 at 7.1 percent and 7.2 percent respectively, which is lower than the national rate of 8.2 percent in 2016.

Babies born to black mothers, however, are much more likely to be low birthweight than children born to mothers of other races. The percentage of low birthweight children born to black mothers in Arizona has held constant from 12.2 percent in 2006 to 11.9 percent in 2015, lower than the comparative national rate of 13.2 in 2016.[7]

Infant Mortality

The first year of life presents the greatest risk for child death. Similar to the trend in low birthweight, the rate of children under one year-of-age who died due to a variety of causes decreased in Arizona from 6.3 per 1,000 live births in 2006 to 5.4 in 2016.[8] Non-Hispanic whites and Asian or Pacific Islanders had the lowest infant mortality rates in 2016 at 3.9 per 1,000 whereas blacks had the highest rate at 11.4 per 1,000, followed by American Indian or Alaska Native at 8.3 per 1,000. Hispanics followed whites at 6.0 per 1,000 in 2016.

Health Insurance

Health insurance is associated with access to and utilization of health care.[9] Across the nation, four percent of children lacked health insurance in 2016, compared to seven percent or 119,000 Arizona

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[6] Federal Interagency Forum on Child and Family Statistics. *America's children: Key national indicators of well-being, 2018.* Washington, DC: U.S. Government Printing Office.

[7] PRB analysis of Centers for Disease Control and Prevention data: National Center for Health Statistics, CDC Wonder 2016 birth data. Retrieved from: https://datacenter.kidscount.org/data/tables/9817-low-birth-weight-babies-by-race#detailed/1/any/false/870/4038,4040,4039,2638,2597,1353,4758/19108,19109

[8] Arizona Health and Vital Statistics (Various Years), Bureau of Public Health Statistics, Various Health Statistics, Deaths, Arizona Department of Health Services. Retrieved from: https://pub.azdhs.gov/health-stats/menu/index.php?pg=deaths; Table 5E-16.

[9] Frederico, S. G., Steiner, J. F., Beaty, B., Crane, L. & Kempe, A. (2007). *Disruptions in Insurance Coverage: Patterns and Relationship to Health Care Access, Unmet Need, and Utilization Before Enrollment in the State Children's Health Insurance Program.* Pediatrics, 120(4), e1009-1016.

children. The numbers of uninsured in the nation, and in the state, are less than half of what they were a decade ago. In 2008, Arizona had 17 percent or 283,000 uninsured children, indicating significant progress over the past decade.[10]

Arizona's improvement on this measure is due in large part to the decision in 2016 to reinstate KidsCare health insurance for children from lower-income families who do not qualify for Medicaid and cannot otherwise afford insurance. Health insurance is important for obtaining preventive screenings for health and developmental milestones, and treatment of chronic and acute conditions as well as injuries. The absence of health insurance can cause delays in receiving care resulting in further health complications and places considerable stress on families.

Teen Mortality

As children enter their teenage years, they encounter new risks to their well-being. In Arizona, the adolescent mortality rate in 2017 was 53.7 per 100,000, this was 30.1 percent lower than in 2007. The highest causes of death among Arizona adolescents were unintentional injuries in accidents, suicide, homicide, and illness.[11] The rate of Arizona adolescents between the ages of 15 and 19 who died as a result of suicide varies greatly by gender, with males accounting for 80.6 percent of completed adolescent suicides in 2017. Whereas adolescent suicide rates have increased since 2007, 13.2 per 100,000 in 2017 compared to 8.5 in 2007, homicide rates have decreased. The rate of homicide in 2007 was 13.3 per 100,000 compared to 6.8 in 2017, however the rate remains higher for males (10.4) than females (3.1). The mortality rates for American Indian adolescents in 2017 was 174.4 compared to all groups at 53.7 per 100,000.[12]

Education

Similar to health indicators, children's educational outcomes also vary by race and income. Indicators of educational well-being can be tracked in early childhood and extend through high school graduation rates. This section examines two indicators of educational well-being, one at each end of the developmental continuum: 4th grade reading proficiency and four-year high school graduation rates.

4th-Grade Reading Proficiency

Reading is the foundation for learning. Until third grade, children are learning to read, by fourth grade children who have not learned to read are at risk of being left behind academically. In Arizona, 90 percent of American Indian fourth-grade public-school students scored below the proficient level in reading in 2017, as measured and defined by the National Assessment of Educational Progress (NAEP), compared to 80 percent of black and 82 percent of Hispanic students in public schools. In contrast, 42 percent of Asian or Pacific Islander and 54 percent of white children scored below proficient.[13] Public schools include charter schools and exclude Bureau of Indian Education schools and Department of Defense Education Activity schools.

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[10] Population Reference Bureau, analysis of data from the U.S. Census Bureau, 2008 - 2016 American Community Survey. These data were derived from American Fact Finder table C27001 (B,C,D,E,G,H,I). Retrieved from: factfinder2.census.gov
[11] Arizona Health Status and Vital Statistics 2017.
[12] Arizona Health and Vital Statistics (Various Years), Bureau of Public Health Statistics, Various Health Statistics, Deaths, Arizona Department of Health Services. Retrieved from: https://pub.azdhs.gov/health-stats/menu/index.php?pg=deaths; Table 5E-26.
[13] For a more detailed description of education achievement, see: http://nces.ed.gov/nationsreportcard/Reading/achieveall.asp.

In addition to its relationship to race, educational disadvantage is related to family income. In schools, income disadvantage is measured using students' eligibility for National School Lunch Program (NSLP), a federally assisted meal program, sometimes referred to as the free/reduced-price lunch program. Free or reduced priced lunches are offered to students with family incomes below 185 percent of the poverty level. Of those students who were eligible for free or reduced price lunch, 83 percent scored below proficient in 4th grade reading, compared to 47 percent of children who were not eligible.[14]

Four-Year Graduation Rates

Race and income based educational advantage begins in early childhood and continues throughout high school and is evidenced by four-year graduation rates.[15] Four-year high school graduation rates have been increasing in Arizona and nationally. Nationally, the 2015-2016 on time graduation rate was 84 percent, considerably higher than 79.5 percent in Arizona.[16] Arizona's rate was up from 75 percent in 2008.[17] Students of Asian descent had the highest four-year graduation rate at 89 percent, in contrast to a low of 67.7 percent for American Indian or Alaskan Native students, 84 percent for white, 76.4 for Hispanic, 75.5 percent for black, and 76.7 percent for economically disadvantaged students.[18]

Safety

Although families are children's main source of support and nurturance, they are also the most likely to perpetrate harm to children physically and psychologically. A family's circumstances can also put children at risk when they live in unsafe communities and do not have access to quality and affordable child care. Adverse childhood experiences (ACEs) are stressful and traumatic events that occur in childhood and that can disrupt a child's brain development and impair their ability to cope and function.

Adverse Childhood Experiences

Arizona has the highest rate in the nation for the percentage of children birth to 17 years who have experienced two or more ACEs.[19] Parental separation and economic hardship are the most common ACEs reportedly experienced by Arizona children. Whereas half of Arizona children have experienced at least one ACE,   18 percent have experienced three or more.[20] The number of ACEs a child experiences

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[14] U.S. Department of Education, National Center for Education Statistics, National Assessment of Educational Progress (NAEP). Available online at http://nces.ed.gov/nationsreportcard/.

[15] High school graduation membership in a cohort class is established at the time of the student's first enrollment in a high school grade. It is computed on the typical four-year expectation for graduation, based on the high school grade in which the student first enrolled. The student's identity with the cohort class remains the same, regardless of student transfers, credits earned, time spent out of state and out of school, and the time necessary for the student to complete requirements for graduation. When calculating the graduation rates for subgroups, membership in a subgroup depends on the student's information at his or her last enrollment of record. Graduates are students who have met the requirements to receive a high school diploma. Students are considered as graduating on time for the four-year graduation rate if they graduate any time prior to September 1st of the following school year.

[16] U.S. Department of Education, Office of Elementary and Secondary Education, Consolidated State Performance Report, 2015-16. See Digest of Education Statistics 2017, table 219.46 Retrieved from: https://nces.ed.gov/programs/coe/indicator_coi.asp#info

[17] Annie E. Casey. (2018). 2018 *Kids Count Data Book*.

[18] ED Facts Data Groups 695 and 696, School year 2015-2016; October 25, 2017; National Center for Educational Statistics.

[19] The Arizona ACE Consortium. (n.d.). *From ACEs to Action: Working Together to Educate, Engage, and Advocate for Positive Change*. Phoenix, AZ: Author.

[20] Ibid.

is positively correlated with health conditions such as depression, heart disease and diabetes as well as behavioral risks including poor academic performance and substance abuse. Child abuse and neglect, parental incarceration and sex trafficking are all examples of adverse childhood experiences.

Child Abuse and Neglect

Child maltreatment increases the risk of poor developmental, health, education, and economic outcomes that extend over the life cycle and affect future generations.[21] The number of confirmed victims of child abuse and neglect in Arizona were down in 2016 (10,779) from 2015 (11,862).[22] Non-Hispanic whites represented 32 percent of victims in 2016, Hispanics 37 percent, American Indians four percent, and blacks eight percent.[23] Comparing these proportions to the overall child population presented in Table 1, black children are noticeably overrepresented in the child maltreatment population. In addition to maltreatment, family circumstances such as parental incarceration can leave children vulnerable to safety concerns that include assault and sex trafficking.

Parental Incarceration

Incarceration of both men and women has become more prevalent across the country with an increasing number of children affected by parental incarceration. Research has shown that the rate of incarceration for black adults is nearly six times the rate of white adults, with black adults more likely to experience long sentences.[24] Latino families and families with low incomes are also disproportionately impacted by incarceration. In 2011-2012 it was estimated that 138,000 or nine percent of Arizona children had an incarcerated parent.[25] The impact of incarceration does not end when the parent is released. Children often continue to suffer the consequences in terms of stigma, housing restrictions, and long-term poverty that place them in low income and unsafe communities.[26]

Sex Trafficking

Under federal law, the crime of sex trafficking is defined as the recruitment, harboring, transportation, provision or obtaining of a person for the purpose of a commercial sex act where such an act is induced by force, fraud or coercion, or in which the person induced to perform such act has not attained 18 years of age.[27] Tracking the number of child sex trafficking victims is a relatively new endeavor, and as a result it is unknown whether or not the incidence is increasing. According to the ASU Office of Sex Trafficking Research, there were 560 unique victims identified in Arizona in 2015 and 2016.[28] Sex trafficking places youth at risk of violence, and poor health, education, and social/emotional outcomes.

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[21] Sattler, K. M. P., & Font, S. A. (2017). Resilience in young children involved with child protective services. *Child Abuse and Neglect, 75,* 104-114.

[22] Kids Count Data Book. Retrieved from: https://datacenter.kidscount.org/data/tables/9909-children-who-are-confirmed-by-child-protective-services-as-victims-of-maltreatment-by-race-and-hispanic-origin?loc=4&loct=2#detailed/2/4/false/870,573/2638,2601,2600,2598,2603,2597,2602,1353/19244,19245

[23] Ibid.

[24] Fwd.us (December, 2018). *Every Second: The Impact of the Incarceration Crisis on America's Families.* Author.

[25] The Annie E. Casey Foundation. (April, 2016). *A Shared Sentence: The Devastating Toll of Incarceration on Kids, Families and Communities.* Author.

[26] Ibid.

[27] U.S. Department of Homeland Security. (n.d.). *What is Human Trafficking?* Retrieved from: https://www.dhs.gov/blue-campaign/what-human-trafficking

Summary

Families are smaller. Fertility patterns have changed. Women and men who are mothers and fathers are working more outside of the home. Families are increasingly diverse - including those who are isolated, extended, and single parent householders. Over time, society has become more accepting of diversity as evidenced by legislation affecting same sex parents' ability to marry and adopt and the gendered use of public bathrooms. Yet, children's relative advantage across the four outcome domains examined in this chapter is marked more by diversity than by chance.

Although its form and the specific ways in which it carries out certain key functions has changed over time, there has always been in recorded history a basic social unit called the family. Perhaps it is because family functions are often described in relation to children, e.g., procreation and socialization, that the concept of family is often pictured as some constellation of adults with dependent children. The family, as an institution, is considered more capable of fulfilling the physical and social needs of children than any other mechanism. For this reason, it is impossible to discuss child well-being without referencing the family.

As the structure and functions of the modern family have been questioned, it is not uncommon to hear the perspective that the family as we know it has deteriorated and is the root cause for many of society's ills including divorce, justice involvement, and drug use. Is this view nostalgia for the past, or objective reality? When we refer to current challenges facing the family, what families do we have in mind? If policies and programs are developed to "strengthen" families, how realistic is our view of the family? If children are the sole responsibility of the family, then how capable is the family to assure their well- being?

Overall, children in Arizona are not worse off than they were in the past as seen by improvements in indicators such as decreased teen birth and child poverty rates, increased rates of health insurance coverage, and decreased rates in low birth weight and infant mortality. The tendency, however, has been to treat such indicators as individual phenomenon and pay little attention to their connectedness and broader implications. There have been decreases in child poverty, however as seen in this chapter, the gains have not materialized for all groups. In health, more children are insured, however, similar to poverty, the increase is not consistent across groups. In education and safety, there is also disadvantage marked by race. As the Arizona child population becomes increasingly diverse, it is clear that large groups are relatively disadvantaged.

To avoid a society where those who have and those who have not are divided on the basis of race, any public response should consider the substantial variation among the different groups. The policies and programs to support children should take into consideration diversity in race and income and family circumstances that disadvantage children. Rates and averages that allow the examination of trends across time mask considerable subgroup disadvantage that is resistant to change. To move the needle on indicators of well-being for all children, discussions of policy and programmatic outcomes should pursue a nuanced approach that includes a focus on race.

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[28] Roe-Sepowitz, D. Bracy, K., Hogan, K., & Bandak, L. (October, 2017). *Incidence of Identified Sex Trafficking Victims in Arizona: 2015 and 2016.* Phoenix, AZ: ASU Office of Sex Trafficking Intervention Research.

ADVERSE CHILDHOOD EXPERIENCES

By Marcia Stanton, MSW
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What Are ACEs?

Adverse Childhood Experiences (ACEs) are traumatic events that take place in a child's life before age 18 that harm children's developing brains and bodies so acutely that the effects show up decades later. The Centers for Disease Control along with Kaiser Permanente conducted a study in 1995 that collected data on more than 17,000 adults regarding their exposure to adverse childhood experiences.[1] In the ACE Survey, adults were asked whether they grew up exposed to any of the following:

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- Alcohol and/or drug abuse in the household
- An incarcerated household member
- Someone in the household who was depressed, mentally ill, institutionalized or suicidal
- Mother who was treated violently
- One or no parent
- Emotional or physical neglect

The number of "yes" answers yields an ACE score that represents a person's cumulative exposure to particular adverse conditions in childhood. If a person experienced none of these conditions in childhood, the ACE score would be zero; an ACE score of nine means that a person was exposed to all of the categories of trauma above.

The ACE study provides compelling evidence that certain health, social and economic risks result from childhood trauma. As the number of ACEs increases, so does the likelihood of cancer, depression, diabetes, alcoholism, smoking, heart disease and other conditions that most often show up in adulthood.[2] In fact, the ACE Study suggests that certain

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Five Facts About ACEs

1. ACEs are common. Nearly two-thirds (64%) of adults have at least one.

2. ACEs are associated with adult onset of chronic disease, such as cancer and heart disease, as well as mental illness, addictions, violence, and being a victim of violence.

3. ACEs don't occur alone. If you have one, there's an 87% chance that you have two or more.

4. The more ACEs you have, the greater the risk for chronic disease, mental illness, addictions, violence, and being a victim of violence. People with high ACE scores are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, more depression, and more autoimmune diseases.

5. ACEs are responsible for a big chunk of workplace absenteeism, and for costs in health care, emergency response, mental health, child welfare, and criminal justice.

Source: ACEs Too High. (n.d.). ACEs Science 101. Obtained from https://acestoohigh.com/aces-101/

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[1] Centers for Disease Control and Prevention. (2016). *About the CDC-Kaiser ACE Study*. Retrieved from: https://www.cdc.gov/violenceprevention/acestudy/about.html
[2] Ibid.

childhood experiences are major risk factors for the leading causes of illness and death in the U.S.[3]

How Home Plays a Role

Children's bodies adapt and develop in direct relation to their environments. In fact, studies have shown a significant correlation between ACE scores and home environment. Higher ACE scores were found in children who:[4]

- Live in poverty.
- Live in unsupportive neighborhoods.
- Spend hours playing video games and watching television.
- Have a physically ill parent.
- Have problems at school.
- Have fewer family supports.
- Are an ethnic minority.

What's more, minority children have a disproportionately higher share of six or more ACEs.

The Negative Effects of ACEs Across the Lifespan

Research on the biology of stress shows that being exposed to "toxic" levels of stress harms the developing brain and other organs. Toxic stress occurs when a child experiences strong, frequent or prolonged adversity, such as extreme poverty, abuse or exposure to violence, substance abuse or mental illness, without the buffering presence of supportive adults.

ACEs activate the stress response system, disrupting brain and organ development and weakening the defense system against diseases.[5] The more ACEs a child experiences, the greater the chance of health problems later in life. The good news is that although the impact of ACEs can last a lifetime, it doesn't have to.

Protective Factors Help to Mitigate Impact of ACES

Not all youth exposed to ACEs are affected in the same way, and in fact many children are resilient, are able to heal, and go on to thrive. Various risk and protective factors among the child, family, and community can impact the ways in which children process and understand the exposure to violence.

According to the Center for the Study of Social Policy, research has identified five protective factors that build family strengths and family environments that promote optimal child and youth development. These include: parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children.

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[3] Centers for Disease Control and Prevention. (2016). *About the CDC-Kaiser ACE Study*. Retrieved from: https://www.cdc.gov/violenceprevention/acestudy/about.html

[4] Injury Prevention Center, Strong Families. (n.d.). *Adverse Childhood Experiences in Arizona*. Phoenix, Az: Phoenix Children's Hospital.

[5] ACEs Too High. (n.d.). *ACEs Science 101*. Retrieved from: https://acestoohigh.com/aces-101/

Importance of Using a Trauma Informed Lens with Children and Families

Looking through a trauma-informed lens means being sensitive to the impact of trauma on others and yourself, understanding and utilizing tools to support self and others in regulating emotions during times of stress; as well as identifying and supporting the system change needed to reduce re-traumatization. Most of all, it seeks to prevent re-traumatization and to promote recovery and resilience through trauma-informed service delivery.

Trauma Informed Care (TIC) integrates core principles of neurodevelopment, trauma and attachment with mindful healing to support a comprehensive approach that can used by clients, providers, and community members.[6]

Examples of Best Practices in Arizona

In 2016, Holiday Park Elementary School in the Cartwright School District embarked on a journey to become more trauma sensitive. Some of the changes they made included having teachers greet every child individually in the morning to assess the child's current state, structured recess games so all children have a chance to be involved, and incorporating 30-second brain breaks during the day to help the children calm down. In two short years, the impact has been remarkable. Holiday Park Elementary School has achieved 7 growth points on AzMerit going from a C school to a B (the only school in district to go up a letter grade). They have also increased teacher retention. They also saw improvements in some of the important data points they track. For example, when looking at Holiday Park's 2018 first quarter data compared to 2017 first quarter data, the school saw a 78 percent decrease in student office referrals and a 19 percent decrease in staff absenteeism.[7]

Arizona's Biggest Challenge in Addressing ACEs: Pay Now – or Pay More Later

Though our brains retain the capacity to change and adapt as we grow older, the neurological response to early toxic stress never goes away, with costly consequences for both children and society. In a nutshell, nurturing environments – or lack of them – affect the development of brain circuitry. Trying to change behavior or build new skills on a foundation of damaged circuitry requires more work, is more expensive and produces worse outcomes than providing nurturing, protective relationships and appropriate learning experiences earlier in life.

Arizona's future prosperity depends on its ability to foster the health and well-being of the next generation. Encouraging positive environments and experiences in our communities will pay dividends both in improving the health of the future adult as well as for the state as a whole.[8]

Important Considerations for Arizona

This is an exciting time for Arizona. The growing body of knowledge about ACEs and their impacts holds promise for our state's ability to improve its citizens' lives. The most effective treatment is to reduce

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[6] Transitions Mental Health Association. (n.d.). Using a Trauma Informed Lens. Retrieved from: https://www.t-mha.org/event-details.php?id=28

[7] For more information please view the following video https://youtu.be/hkxxN67d2pA

[8] Injury Prevention Center, Strong Families. (n.d.). *Overcoming Adverse Childhood Experiences: Creating Hope for a Healthier Arizona.* Phoenix, Az: Phoenix Children's Hospital.

young children's exposure to adverse conditions, such as abuse, neglect, violence, or caregiver mental illness or substance abuse. However, even under stressful conditions, the negative consequences of toxic stress can be mitigated. Stable, nurturing relationships with caring adults can prevent or reverse the damaging effects of toxic stress. Therefore, it is also important to create safe spaces and strong, healthy communities for children.

Assuring safe, stable, nurturing relationships and environments for all children is essential for Arizona's future prosperity. That is why it is key to improve the health and well-being of children, families and communities across the state by working to address ACEs in the context of adverse community environments.[9]

Options for Addressing the Impacts of Toxic Stress

The growing body of knowledge about ACEs offers suggestions about how Arizona can respond and make a positive impact on its citizen's lives. To effectively address ACEs and toxic stress, it is important to understand the scope of the problem. Gathering data on the prevalence of ACEs throughout Arizona could be a first step. Other potential options include:[10]

- Educate leaders, policymakers, pediatricians, other healthcare professionals, and the public about ACEs, brain development and effective interventions.
- Promote and bring to scale research-informed, community driven and cost-effective trauma and adversity prevention and recovery strategies, services and programs.
- Engage elected and appointed officials, private-sector leaders and other influencers as champions for health, education, economic and related policy changes that improve community resilience, health equity and social justice.
- Build a comprehensive, integrated system for identifying, screening and treating adverse childhood experiences.
- Craft a statewide response to ACEs in Arizona.

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[9] Injury Prevention Center, Strong Families. (n.d.). *Overcoming Adverse Childhood Experiences: Creating Hope for a Healthier Arizona*. Phoenix, Az: Phoenix Children's Hospital.
[10] Injury Prevention Center, Strong Families. (n.d.). *Adverse Childhood Experiences in Arizona*. Phoenix, Az: Phoenix Children's Hospital.

STRENGTHENING FAMILIES AND PROTECTIVE FACTORS

By Claire M. Louge, M.Ed.
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Working with Families to Improve Long-Term Outcomes for Children

The prosperity and long-term success of Arizona depends on the healthy development of its children, who will become our future workers, decision-makers and leaders. A child's family is foundational to his or her development; the family is the context within which child development happens. Collectively working to strengthen families and increase family capacity to promote child development can be a way to invest in society's long-term success.

This section will present information on how to strengthen Arizona families by increasing family capacity to be resilient to stressors. It will also present information on how to promote child development so that children's needs are met and they are free from harm so that their brains and bodies are able to develop.

This chapter will first consider effective approaches to working with families. The chapter also contains examples of effective strategies that individuals, organizations and communities can use to strengthen families. Some programs are highlighted in this chapter to exemplify effective strategies.

Approaches to Family Support

In order to effectively work with families, the approach to the work is just as important as the work itself. Services offered to families are always conducted within the context of a relationship between a parent and a provider. The quality of this relationship matters. Without a relationship built on safety and trust, effective teaching will not occur. Therefore, in order to build a trusting relationship between parent and provider, consider the following approaches:

- **Focusing on Strengths –** A strength-based approach is an effective approach. Focusing on flaws or weaknesses does not provide the motivation or skills needed to create sustainable change. Systems and practices that focus solely on identifying and reducing risk may disengage families by causing them to feel stigmatized, judged and hopeless. In order to create effective and long-term change, families build upon their current strengths and utilize these strengths as a solution to their challenges.[1]

- **The Trauma-Informed Approach –** The trauma-informed approach is a way of working with

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[1] Center for the Study of Social Policy. (2018). *Strengthening Families: Increasing Positive Outcomes for Children and Families.* Retrieved from: cssp.org/our-work/project/strengthening-families/

people who considers the impact of their past experiences on their current reality. Adverse Childhood Experiences (ACES), including child abuse, alcohol abuse in the home, substance abuse in the home, or having an incarcerated family member, can create toxic stress, a long-term stress response that disrupts the healthy development of a child's brain. This disrupted development increases a child's risk of developing lifelong health and social problems.[2]

Basically stated, this is because early experiences build the brain. When the brain experiences chronic stress (such as stress caused by ACEs) without the buffer of positive, nurturing relationships, the parts of the brain responsible for responding to stress overdevelop, and the other parts of the brain that control other functions, such as impulse control, emotional regulation and decision-making, do not develop sufficiently. A child's stress response becomes chronically over-reactive, and because it is harder to make thoughtfully reflective decisions when overwhelmed by stress, this child's potential to succeed – now and in adulthood – suffers.[3]

Nearly half of Arizona children have experienced at least one ACE. [4] These rates increase in populations experiencing poverty, as well as historically under-served demographics, including Native American, Black, and Latino populations.[5]

The trauma-informed approach considers the effect of trauma on the brain, and works to create safe, calming environments that assist individuals to regulate their stress responses and engage in learning and thoughtful reflection. Since effective work with families involves learning and reflection, the trauma-informed approach is critical to working with families.[6]

- **Respecting and affirming culture –** Culture plays a key role in parenting and effectively supporting positive parenting practices. Parents from any cultural background can benefit from learning new information as long as it is respectfully communicated and connects with their cultural traditions. When working with parents, it is preferable to utilize support professionals who have personal experience or understanding of the family's cultural traditions and practices. If such a person is not available, it is important for any service provider to approach families with curiosity and a desire to learn, rather than forming judgements and assumptions. As long as children are nurtured, safe and thriving, parenting along the mainstream isn't essential.[7]

- **Including parents in decision-making –** It is easy to make assumptions about what parents and families need based on our own experiences, the theories we have learned, or the strategies we have been taught to apply. Even the most well-intentioned, educated family service professional can be ineffective if she does not include the parent in decision-making about the work they are doing together. Effective work with families is built upon a trusting, communicative relationship

[2] Felitti, Vincent J, et al. (May 1998). *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults*. American Journal of Preventive Medicine. (vol. 14, no. 4). doi:10.1016/s0749-3797(98)00017-8.
[3] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition. Retrieved from: http://www.developingchild.harvard.edu
[4] The Arizona ACE Consortium. (n.d.). *From ACEs to Action: Working Together to Educate, Engage, and Advocate for Positive Change*. Phoenix, AZ: Author.
[5] Ibid.
[6] Substance Abuse and Mental Health Services Administration. (27 Apr. 2018). *Trauma-Informed Approach and Trauma-Specific Interventions*. Retrieved from: www.samhsa.gov/nctic/trauma-interventions
[7] National Alliance for Children's Trust & Prevention Funds. (2012). *Bringing the Protective Factors to Life in Your Work– A Resource for Action*.

between the family and the provider. In order to create effective change, it is critical for family-serving agencies to include the voices of the families they serve in their decision-making processes.

All of these approaches work to build a trusting relationship between families and the people/professionals/organizations/communities who are working to support them. Without this foundational relationship, strategies will not be implemented effectively or sustainably.

Strategies to Work with Families: The Strengthening Families Protective Factors

The Strengthening Families™ Protective Factors Framework is a research-informed approach to working with families in a way that builds their strengths as a solution to their challenges. It was developed by the Center for the Study of Social Policy (CSSP) in Washington, D.C. in order to provide a framework for increasing family strengths, enhancing child development and reducing the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five key protective factors:

- Parental Resilience
- Social Connections
- Knowledge of Parenting and Child Development
- Concrete Support in Times of Need
- Social and Emotional Competence of Children

The sections below will define each protective factor and offer strategies to help families build these strengths.

Parental Resilience

Parental resilience is the ability to recover after something hard or unexpected happens, and being able to cope with stress. It includes a parent's ability to recognize and navigate challenges, apply positive self-regulation behaviors, and continue to care for their children despite the inevitable stress that life and parenting present. Parents who are resilient are able to take good care of their children even when they are experiencing a crisis.[8]

Children learn about resilience by watching or being around their parents when they practice resilience. When parents exemplify self-regulation and stress-reduction strategies, co-regulation is able to occur. Co-regulation is the concept of a parent regulating their stress response, and by doing so, improving a child's ability to regulate their own stress response.

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[8] Center for the Study of Social Policy. (2018). *Parental Resilience: Protective and Promotive Factors*. Retrieved from: https://cssp.org/wp-content/uploads/2018/08/HO-2.1a-CW-Parental-Resilience.pdf

General Strategies to Build Parental Resilience

Individuals, communities and organizations can help build *parental* resilience by:

Responding to family crises – Noticing when families are going through challenges and connecting them to resources and support that address that particular crisis improves the likelihood of a positive outcome, and helps parents learn how to navigate a similar crisis in the future.

Resilience can be built before a crisis happens, or built as a crisis is happening. Promoting parental resilience means helping parents build traits and skills including help-seeking, communication, hope, self-confidence, self-awareness, and stress-reduction strategies. Parental resilience is predicted by certain qualities, including optimism, sense of purpose, spirituality, emotional awareness, emotional regulation, psychological endurance, compassion, social support, and generativity (giving back to the community). When we work with parents and caregivers to build these qualities, they are more likely to be resilient.

These qualities can be built through practices including exercise, journaling, establishing self-care routines, volunteering, engaging in social activities with other parents, and mindfulness meditation.[9]

Valuing and supporting parents – Having a generally respectful, kind, and non-judgmental demeanor increases the likelihood that a parent will reach out for help when they need it. Valuing and supporting parents also means implementing policies that value the role of parents in our community as children's first and most important teachers.[10]

General Strategies to Build Social Connections

Individuals, communities and organizations can help build social connections by:

Facilitating friendships and mutual support – Helping parents connect with each other and develop social networks helps improve their capacity to manage their stress, cope with challenges, and access resources in their community. *Social connections* among parents also help them learn from one other.

Although human beings need other human beings to survive and thrive, social connections are sometimes difficult to build, maintain and sustain. Being able to connect with others requires certain skills, including self-awareness, communication, and listening. Helping parents build these social skills may be the first step in supporting them to build *social connections*.

To help build *social connections* among parents, families need consistent opportunities to connect to one another. Community events, such as library story hours, festivals, faith gatherings and school-based socials all provide the space for parents to connect to one another. Communities can support family social connections by ensuring events are accessible, affordable, and relevant to families.[11]

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[9] Center for the Study of Social Policy. (2015). *Core Meanings of the Strengthening Families Protective Factors*. Retrieved from: https://cssp.org/resource/core-meanings-of-the-strengthening-families-protective-factors/
[10] Hamby, S., Grych, J., & Banyard, V. (2018). *Resilience portfolios and poly-strengths: Identifying protective factors associated with thriving after adversity*. Psychology of Violence, 8(2), 172-183.
[11] Center for the Study of Social Policy. (2018). Social Connections, Protective and Promotive Factors. Retrieved from: https://cssp.org/wp-content/uploads/2018/08/SF_Social-Connections.pdf

Social Connections

Social connections are the people in our lives who help us be who we want to be. *Social connections* can provide positive emotional, spiritual, informational, and concrete support. *Social connections* are not just about having people to have fun with, they're about having people to turn to. Quality of connections, rather than quantity of connections, matters.

Being socially connected means having someone to call or contact in a time of stress or crisis. It includes the feeling of belonging and connection to community. Parents specifically need to have social connections they can talk to about parenting so that they may obtain tools, skills or ideas when facing parenting challenges.

General Strategies to Build Knowledge of Parenting and Child Development

Individuals, communities and organizations can help build knowledge of parenting and child development by:

Promoting knowledge of parenting and child development – The wide availability of the internet has created a quickly accessible, vast and ever-growing body of information and misinformation about parenting and child development. Promoting *knowledge of parenting and child development* involves ensuring that parents have access to high-quality, factual, and reliable information and supporting parents to find the content that they need. Now more than ever, promoting knowledge of parenting and child development depends on the quality of the relationship between parent and provider. With the unprecedented access to both unreliable and reliable information, parents turn to people they trust to help them make parenting decisions.[12]

Parenting classes are a classic example of promoting knowledge of parenting and child development. These courses serve the dual function of teaching parenting skills and promoting social connections among parents. These classes, in order to be effective, should be at convenient times, provide child care, and be designed in response to the stated needs of the parents attending them.

Home visiting services, which offer families individual support through visits from a professional family support specialist, are another example of effective parenting education. These services are designed to work with parents in a way that specifically meets their unique family's needs. Both parenting classes and home visitation services will be discussed later in this document.

Parents need social connections to be healthy. *Social connections* are a critical part of resilience, self-care, and having a sense of hope. *Social connections* help relieve stress. Parents who model maintaining healthy relationships help their children learn what positive relationships look like.

Knowledge of Parenting and Child Development

Knowledge of parenting and child development is having the skills and information needed to nurture the healthy development of a child. It is understanding the child's current developmental needs and unique nature, and knowing what to expect for their future development. It includes the formation and maintenance of a secure attachment of the child to the parent, and the establishment of a consistent, nurturing relationship. Application of knowledge of parenting and child development requires the parent to have confidence, courage, and the ability to self-regulate.

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[12] Center for the Study of Social Policy. (2018). Knowledge of Parenting and Child Development, Protective and Promotive Factors. Retrieved from: https://cssp.org/resource/sf-knowledge-of-parenting-and-child-development/

Concrete Support in Times of Need

Every family, at some point, will need help. Whether it is a sudden illness, a job loss, a new baby, or a move to a new community, parents will be faced with something that requires the support of others. When highly stressful things occur, and when parents don't have the knowledge, skills, or resources to face the situation's challenge, they need support. When families have *concrete support in times of need*, they are able to identify what they need, where to find help, and how to ask for help.

General Strategies to Build Concrete Support in Times of Need

Individuals, communities and organizations can help build concrete support in times of need by:

Linking families to services and opportunities – Anyone can help build concrete support in times of need by taking time to learn about the available resources in their community. This way, when a parent needs help, an individual is better able to refer a parent to needed support or services. Opportunities like parent resource fairs can help to inform parents of available resources. Oftentimes, however, a service is sought when there is an emergent need for it. Ensuring resource information is quickly obtainable with a quick internet search may be the most effective way to link modern parents to services and opportunities.

Again, the importance of relationships is paramount to a parent's ability to seek and find help. Asking for help is a vulnerable action, one that requires trust of the person being asked. Promoting trusting relationships between parents and providers works to ensure that parents will be able to ask for help when they need it.

Observing early warning signs of child abuse and neglect – Stress impedes good decision-making. When a parent experiences a high-level of stress, especially if they have experienced trauma in childhood, their biological stress response may cause them to act in an impulsive manner and prevent them from making sound decisions. Because of the biology of stress, strengthening families is largely about helping to manage stress.

When a parent is visibly stressed, this is the earliest warning sign of child abuse and neglect. This does not mean that all stressed parents will abuse or neglect their children, it means that the root of the vast majority of child abuse is caregiver stress. When a parent is observed as stressed, it is time to intervene to prevent the consequences of overwhelming stress on a family and child. Observing and responding to early warning signs of child abuse means reaching out to the parent to offer resources and support. As always, this is best done within an established trusting relationship.[13]

Accessing help in times of need requires a parent to believe that they deserve help and know that they will not be shamed for asking for this help. For that reason, building *concrete support in times of need* is as much about promoting help-seeking behavior as it is about promoting awareness of the availability of resources to help.

When parents don't have concrete support in times of need, the stress level caused by the unmet need can impede their ability to make reflective decisions, and they are more likely to behave in ways that may affect their family negatively.

Children's Social and Emotional Competence

The way that children act is usually a reflection of what's happening in their family and their world. The way that children act also affects their family. When a child has *social and emotional competence,* it

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13 Center for the Study of Social Policy. (2018). *Concrete Support in Times of Need, Protective and Promotive Factors*. Retrieved from: https://cssp.org/wp-content/uploads/2018/08/SF_Concrete-Support-in-Times-of-Need.pdf

positively affects how they act in the world and how the world acts towards them.

Children who have *social and emotional competence* have a strong sense of self-worth, are able to maintain positive relationships, and are able to manage their stress. Since most of human achievement is driven by relationships, social and emotional skills also propel their future success. Children that have these skills form healthier relationships, handle stress better, have better behavior, and do better in school. These skills also make them easier to parent, which reduces stress for the whole family.

General Strategies to Build Children's Social and Emotional Competence

Individuals, communities and organizations can help build children's social and emotional competence by:

Facilitating Children's Social and Emotional Competence – Social and emotional competence in children is built through interactions with positive, attentive, nurturing adults. Children learn how to treat others and themselves through observation and imitation. Since high stress and threats interfere with learning, in order to effectively learn social and emotional skills (or any other skill), children must first be in an environment that is safe.

Parents can nurture children's social and emotional learning with strategies including reading books together, teaching children a vocabulary for their emotions, and frequently taking time to give their child positive, undivided attention. Limiting screen time for children (such as smartphones and television), especially screen time without the presence of an adult to interact with, is also a good strategy to promote a child's social and emotional competence.

Promoting greater access to affordable high-quality child care is another critical strategy to promote social and emotional competence of children. High-quality early education settings focus on building a positive, nurturing relationship between educators and children, which is the foundation for social and emotional learning.[14]

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[14] Center for the Study of Social Policy. (2018). *Children's Social and Emotional Competence, Protective and Promotive Factors*. Retrieved from: https://cssp.org/wp-content/uploads/2018/08/SF_Social-Emotional-Competence-of-Children.pdf

By Darren DaRonco
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Child Safety Assessment

The Arizona Department of Child Safety (DCS) is entrusted with protecting all of Arizona's children from abuse and neglect. DCS receives and investigates allegations that a child is being abused or neglected, and provides services to strengthen families when abuse or neglect has occurred or is likely to occur. DCS is guided by three core principles.

> **DCS by the numbers**
>
> • 149,071 communications (calls) were made to DCS during state fiscal year 2018.
>
> • Of these 149,071 communications, 32% met the criteria for a report.
>
> • Out of all children that received an investigation, 4,770, or about10%, were removed from the home due to safety concerns.

- **Safety –** All of Arizona's children are safe and protected from harm.
- **Permanency –** All of Arizona's children live in safe, loving forever families.
- **Well-Being –** All of Arizona's children are given the opportunity to thrive through the support of strong families and their communities.

Community members who are concerned that a child is being abused or neglected should contact DCS to report the concern. If the reported information meets the statutory definition of abuse and neglect, a DCS report is generated and forwarded to a local community DCS office for an investigation of the allegations and a family assessment. A Child Safety Specialist meets with the children, parents, and other adults in the home to determine if the children are safe in the care of their parents, evaluate risk of future abuse or neglect, and identify services that can support the parents and strengthen the family. Relatives, teachers, doctors, and others who know the family may also be interviewed to learn about the extent of abuse or neglect in the home, circumstances surrounding any abuse or neglect, the adults' functioning on a day-to-day basis, the children's functioning, and the general parenting and disciplinary practices in the home.

Following investigation, DCS determines if the report should be substantiated or unsubstantiated. When a report is substantiated, DCS has found probable cause to believe child abuse or neglect occurred. The parent or caregiver receives a letter explaining how an appeal of this decision may be requested and how to get a copy of the DCS report. A confidential record of all DCS reports and outcomes is maintained in a computer database.

After thorough information is gathered, the DCS Specialist and a DCS Supervisor review the information, determine whether the child is safe, and whether continued DCS involvement with the family is necessary to maintain the child's safety or reduce risk of future abuse or neglect. When the family will benefit from services or supports, the DCS Specialist engages with the family members to identify the best services to meet their needs.

Families referred to DCS are often struggling with mental health, financial, housing, or health problems and can benefit from supportive assistance. In most situations, DCS is able to provide information about services in the community, and end its involvement with the family. At times, DCS remains involved with the family and provides services in the home, or while the child resides with a relative or in foster care. Just over one of every ten children referred to DCS must be separated from the parents due to dangerous conditions in the home and lack of protective parenting.

> The level of services provided to a family is determined on a case by case basis and/or by court determination. Some services that may be provided to families involved with DCS after the initial investigation are: counseling, substance abuse treatment, child care, housing assistance, parenting skills training, and assistance applying for financial benefits and medical care.

What Are Child Abuse and Neglect?

Child abuse and neglect can have long-lasting, negative health and economic consequences for a community. Abused and neglected children may suffer immediate physical injuries as well as lingering emotional and psychological problems even after the abuse ends.

Abuse and neglect can lead to children having trouble trusting others and forming nurturing relationships; developing anxiety and other mental health disorders; and interfering with their physical, emotional and educational growth. In Arizona, child abuse occurs when a parent, guardian or custodian inflicts, or allows someone else to inflict physical, sexual or emotional abuse on a child, or neglects or abandons a child. While child maltreatment includes all types of abuse and neglect of a child under 18, DCS categorizes abuse and neglect into four categories.

In fiscal year 2018, the Arizona Department of Child Safety (DCS) received 149,071 calls to its child abuse Hotline. Approximately 32 percent of these calls (48,046) met the statutory definition of abuse and neglect were investigated. DCS removed 10 percent of the children (9,670) involved in the reports that were investigated.

In Arizona, the number of children in out-of-home care has dropped 25 percent from a high of 19,000 children in March 2016 to 14,000 children in September 2018.

Neglect

Neglect is the most prevalent type of child abuse and is defined as an on-going pattern of inadequate care.

Neglect is usually reported by individuals who have close contact with a child. Doctors, nurses, and daycare workers frequently report neglect in newborns, toddlers and children too young to attend school. Relatives, police officers and teachers often report neglect of older children and teenagers.

Neglect occurs when parents fail to meet a child's basic physical and emotional needs. While neglect is often viewed in the general public as less harmful than physical or sexual abuse, it is the most frequent type of maltreatment and it can lead to consequences that are as equally detrimental as physical abuse.

Since neglect covers a broad spectrum, DCS divides neglect into four categories: failure to protect, medical, environment and general neglect.

Failure to protect includes subjecting a child to significant or repeated domestic violence incidents that could harm the child; parent allows a child to remain in a home where illicit drugs are manufactured; and a parent who is unwilling or unable to control a child whose behaviors threaten severe harm to the child or others.

Medical neglect involves a parent who is unwilling or unable to address a child's medical needs by either not seeking treatment when a child is sick or injured; or not administering doctor recommended treatments. It also includes medical diagnoses of malnutrition or failure to thrive that can't be explained by an underlying medical condition.

Environmental neglect relates to any surroundings in a home that could threaten a child's safety such as fire hazards, manufacturing illicit drugs, access to dangerous weapons or harmful substances, and extremely unsanitary or infested housing that poses a health hazard.

General neglect encompasses substance-exposed newborns; injuries due to neglect or failure to supervise; parent is unable or unwilling to meet the child's basic needs for shelter, food, or clothing; and the parent is absent and leaves children alone who can't care for themselves or with a person who can't provide adequate care for the children.

Severe neglect in either domain can have adverse impacts on a child's physical health, development, and psychological growth. DCS received 33,989 neglect reports in fiscal year 2018.

Physical Abuse and Sexual Abuse

Physical abuse is defined as the "infliction or allowing of physical injury, impairment of bodily function or disfigurement." This can include bone fractures, brain injuries, burns, bruises, cuts, abrasions or swellings that are inconsistent with the parent's or caregiver's explanation.

It also includes unreasonably confining a child such as locking a child in a cage or a confined space; or tethering a child to an object.

Child injuries that are sustained by allowing that child to enter or remain in a home or vehicle where dangerous substances are found or illicit drugs are manufactured are also considered physical abuse under Arizona law.

Children who suffer physical abuse experience emotional trauma long after the injuries have healed. In fiscal year 2018, DCS received 11,917 physical abuse reports.

Sexual abuse is when a parent or caregiver inflicts or allows "sexual abuse, sexual conduct with a minor, molestation of a child, sexual exploitation of a minor, incest or child sex trafficking."[1]

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[1] See Arizona Revised Statutes §8-201(2)(a) for the complete definition of sexual abuse.

Studies have shown sexual abuse is the least reported form of child abuse due to the stigma and secrecy that is often involved in these cases. Many sexually abused children are reluctant to reveal they are being abused. In many cases, they are deceived or threatened by their abusers to not talk about the abuse.

If a child does not disclose sexual abuse, there are indicators that DCS investigators look for.

Children who are sexually abused will display behavioral and emotional signs such as difficulty eating or sleeping; wetting their pants or bed; acting like a much younger child; crying excessively; and withdrawing from school or family activities.

They could have a sexually transmitted disease or complain of pain in the genital or anal areas.

Children who display persistent, highly sexualized behavior that is grossly age-inappropriate likely learned that behavior from sexual abuse.

DCS received 1,867 sexual abuse reports in fiscal year 2018.

Emotional Abuse

Emotional abuse is defined as a parent inflicting or allowing another person to cause serious emotional damage. Examples of emotional abuse include rejection, name calling, threats, shaming and domestic violence. These behaviors are either a one-time incident or a pattern of behavior by a parent towards a child that affects the child's normal daily behavior.

Children who suffer emotional abuse can display severe anxiety, depression, withdrawal or improper aggressive behavior. The effects of emotional abuse must be diagnosed by a medical doctor or a psychologist before DCS ascribes them to a parent's actions. DCS received 239 emotional abuse reports in fiscal year 2018.

Risk and Protective Factors

Examining risk and protective factors for child abuse is useful when creating prevention and early intervention strategies, and identifying families who could likely benefit from additional support services.

Risk factors for abuse and neglect are the measurable circumstances, conditions or behaviors that increase the probability that a family could experience child abuse or neglect in the future. Multiple risk factors are associated with child abuse. Some common risk factors include parental substance abuse, a history of domestic violence or crime, unemployment, lack of access to economic supports, and social isolation.

Protective factors moderate risks and promote child and family well-being. Every family contains both risk and protective factors to varying degrees. The interaction of several risk factors in combination with limited protective factors may increase the likelihood of child abuse and neglect. Strong protective factors in families can build resilience in children and parents.

When DCS case specialists work with families, they are focused on strengthening the five protective factors to ensure child safety. The protective factors are parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. See the Strengthening Families and Protective Factors chapter for more information.

Conclusion

Child abuse remains a persistent problem in Arizona. Every month, DCS receives hundreds of calls reporting abuse and neglect of our most vulnerable children. Since child abuse and neglect are caused by a variety of individual, family, and environmental factors, it is imperative that different sectors of our community work together to ameliorate its impact on our children.

Child abuse prevention requires a coordinated effort from key sectors of our community such as health care, government agencies, schools, the legislature, social services, and the courts. Only together can we get a handle on this plight.

To report child abuse or neglect to the Department of Child Safety call: 1-888-SOS-CHILD (1-888-767-2445)

When reporting, the following information, if known, will be requested:
- name, age, and gender of child and other family members
- address, phone numbers, and/or directions to child's home
- parents' place of employment
- description of suspected abuse or neglect
- current condition of the child

SPOTLIGHT ON VIOLENCE IN FAMILIES

By Allie Bones
Former Chief Executive Officer, Arizona Coalition to End Sexual and Domestic Violence
Current Assistant Secretary of State to Katie Hobbs

Background

Domestic violence is a pattern of coercive control where one partner uses their power to control the other partner. Domestic violence can take many forms, including physical, sexual, emotional, and financial abuse. It is estimated that 1 in 4 women and 1 in 7 men will experience domestic violence in their lifetime.[1] If we extrapolate that out, in Arizona, this means that over 800,000 women and nearly 500,000 men will experience domestic violence in their lifetime. It is also important to note that Native American women experience domestic violence at rates 50 percent higher than other groups.[2] Domestic violence and Intimate Partner Violence (IPV) are often used interchangeably, but it is important to note that IPV refers to the narrower set of domestic violence incidents in which the people are involved in an intimate relationship (which excludes those involved in family violence).

The effects on children from exposure to IPV varies. Children react to the violence in a variety of ways, with a lot dependent upon the age of the child at the time of the exposure, the duration of the exposure, the severity and frequency of the violence, along with the presence of protective factors that exist in the child's life, especially supportive relationships with non-violent adults (including possibly the victim parent), as well as the child's own resiliency. Effects might be immediate, in relation to a violent incident, on-going throughout childhood and adolescence, or long-term into adulthood.[3]

There are a whole host of impacts that can be attributed to exposure to IPV in children. According to Futures Without Violence:

- A 2003 review of studies of child witnesses concluded that about 63 percent were faring more poorly than the average child who had not been exposed to domestic violence.[4]
- Child witnesses experienced more health complaints, in particular, more eating, sleeping, and pain problems and more self-harm than a population sample in a recent Dutch study.[5]

[1] Centers for Disease Control, National Center for Injury Prevention and Control, Division of Violence Prevention. (2010). *Preventing Intimate Partner Violence*. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/ipv-factsheet.pdf

[2] Kitzmann, K.M., Gaylord, N.K., Holt, A.R., & Kenny, E.D. (2003). *Child Witnesses to Domestic Violence: A Meta-Analytic Review*. Journal of Consulting and Clinical Psychology, 71, 339-352. P. 345.

[3] Lamers-Winkelman, F., Schipper, JC, Oosterman, M. (2012). *Children's Physical Health Complaints After Exposure to Intimate Partner Violence*. Br J Health Psychol. 2012 Nov;17(4):771-84. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/22490127

[4] Summers, A. (2006). *Children's Exposure to DV: A Guide to Research and Resources*. National Council of Juvenile and Family Court Judges. (pp 23-25). Retrieved from: http://www.ncjfcj.org/sites/default/files/Childrens%20Exposure%20to%20Violence.pdf

[5] Yates, T., Dodds, M., Sroufe, A., & England, E. (2003). *Exposure to Partner Violence and Child Behavior Problems: A Prospective Study Controlling for Child Physical Abuse and Neglect, Child Cognitive Ability, Socioeconomic Status and Life Stress*. Development and Psychopathology,15(1), 199-218.

- Overall, studies indicate that Post-traumatic stress disorder (PTSD) is a major concern for children who witness domestic violence, as well as increased experiences of negative emotions, such as anxiety and depression.[6]
- A prospective longitudinal study of high-risk families found that witnessing domestic violence in the preschool years was related to behavior problems at age 16 for both sexes; for boys, middle childhood exposure was related to contemporaneous behavior problems.[7]
- A recent study of college students compared those who had never witnessed interparental violence with those who had witnessed it a few times and those who had witnessed it frequently (more than 10 times). Frequent exposure to domestic violence was a significant risk factor for depression in young adulthood even when confounding variables (other adverse experiences) were controlled.[8]
- A national survey of youth found that more than half of dating violence victims and statutory rape/sexual misconduct victims had witnessed intimate partner violence.[9]
- In a prospective study, exposure to parental violence as a child was the strongest predictor of experiencing domestic violence in adulthood.[10]
- There is increasing evidence that early life stressors, such as abuse, witnessing IPV, and related adverse experiences, cause enduring brain dysfunction that, in turn, affects health and quality of life throughout the lifespan.[11]

In order to reduce risk factors associated with exposure to domestic violence, it is important that we have opportunities to intervene with victims who are experiencing domestic violence. Access to an advocate to assist with safety planning for the victim and child is a key strategy for communities. We also need to look at enhancing interventions with those who use abuse to control and have power over their intimate partners.

Effective Treatments and Services

Victims' Services

Services for victims of domestic violence have traditionally relied upon the emergency shelter model. The anti-IPV community, as well as systems responders such as law enforcement, child protection, and hospitals/health care providers, have largely focused over the years on the need for victims to leave the violent situation by going into a shelter setting. This response, while critical for some, is limiting in its scope of what victims, survivors, children and those who abuse need for the violence to stop. It is a stopgap – an immediate response to the violence that it is happening, but for many victims, they do not

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[6] Russell, D., Springer, K., & Greenfield, E. (2010). *Witnessing Domestic Violence in Childhood as an Independent Risk Factor for Depressive Symptoms in Young Adulthood*. Child Abuse and Neglect 34(6), 448453.

[7] Hamby, S, Finkelhor, D., Turner, H., & Ormrod, R. (2010). *The Overlap of Witnessing Partner Violence with Child Maltreatment and other Victimizations in a Nationally Representative Survey of Youth*. Child Abuse and Neglect 34, 734-741.

[8] Ehrensaft, M.K., Cohen, P., Brown, J., et al. (2003). *Intergenerational Transmission of Partner Violence: A 20-Year Prospective Study*. Journal of Consulting and Clinical Psychology 79(4), 741–753.

[9] Anda, R., Felitti, V., Bremner, J.D., Walker, J.,Whitfield, C., Perry, B., Dube, S.& Giles, W. (2006). *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology*. Eur Arch Psychiatry Clin Neurosci. 2005;256(3):174-86.

[10] Hart, B. (2014). *Serving Valley Victims of Domestic Violence: Challenges and Choices*. Morrison Institute for Public Policy. Retrieved from: https://morrisoninstitute.asu.edu/node/155

[11] Anda, R., Felitti, V., Bremner, J.D., Walker, J.,Whitfield, C., Perry, B., Dube, S.& Giles, W. (2006) The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. P.2.

want to take their children into a shelter, and the reality is that shelter is a limited resource that is not always available or appropriate to the situation.

In recent years, there has been a goal to expand access to domestic violence advocates throughout the state in settings that are not strictly shelter-based settings. There have been examples of service providers having advocates based in the community, especially in court or probation settings, yet, with one exception – Jewish Family and Children's Services' Shelter Without Walls – most advocates were either phone-based or in shelters. About five years ago, that changed when two domestic violence programs in the state, Eve's Place in Phoenix and Emerge! Center Against Domestic Abuse in Tucson, expanded their services. Eve's Place significantly reduced, and eventually eliminated their emergency shelter program and moved to a Mobile Advocacy Program model in which advocates meet with victims where they are – home, work, school, coffee shop, wherever. They set up support groups several nights a week at locations throughout the community that were open to anyone sheltered and unsheltered. The model has proven to greatly expand access to services for survivors. Emerge! closed 70 of their shelter beds (out of 120) and opened a community-based advocacy program, as well as a rapid rehousing program. They are now able to provide services to more victims as well as provide the short-term housing supports that many survivors need in order to achieve stability on their own.

In 2017, the Department of Economic Security (DES), the state agency that administers the state domestic violence prevention line item, made mobile and community based advocacy and rapid rehousing priority services under their contracts. While emergency shelter is still the largest allocation from DES, many programs expanded their services so that they too now offer mobile and community based advocacy services, with some programs also now offering a rapid rehousing program. Victims' opportunities to access advocacy services have expanded greatly beyond shelter.

Batterer Intervention

The most common form of batterer intervention throughout the country, including here in Arizona, is the Duluth model. Curriculum typically addresses (the following topics in 2-4 hour sessions, typically over 26 weeks):

- Nonviolence
- Non-threatening behavior
- Respect
- Trust & Support
- Honesty and Accountability
- Sexual Respect
- Partnership
- Negotiation and Fairness

The primary focus is on dismantling behaviors outlined in the popular Power and Control Wheel, and not necessarily addressing the root causes of those behaviors.

The Duluth Model Approach

A commitment to shift responsibility for victim safety from the victim to the community and state

A shared collective mission and strategy regarding intervention that is based on a number of core philosophical agreements

A shared understanding of how interventions are to be accountable to victim safety and offender accountability

A shared understanding of how each agency's actions either support or undermine the collective goals and strategy of intervention

Shared definitions of safety, battering, danger and risk, and accountability.

Prioritizes the voices and experiences of women who experience battering in the creation of those policies and procedures.

Source: Domestic Abuse Intervention Programs. (N.D.). *What is the Duluth Model?* Obtained from https://www.theduluthmodel.org/what-is-the-duluth-model/

VIOLENCE

PHYSICAL · SEXUAL

POWER AND CONTROL

USING COERCION AND THREATS
• Making and/or carrying out threats to do something to hurt her • Threatening to leave her, commit suicide, to report her to welfare • Making her drop charges • Making her do illegal things

USING INTIMIDATION
• Making her afraid by using looks, actions, gestures • Smashing things • Destroying her property • Abusing pets • Displaying weapons

USING ECONOMIC ABUSE
• Preventing her from getting or keeping a job • Making her ask for money • Giving her an allowance • Taking her money • Not letting her know about, or have access to, family income

USING EMOTIONAL ABUSE
• Putting her down • Making her feel bad about herself • Calling her names • Making her think she's crazy • Playing mind games • Humiliating her • Making her feel guilty

USING MALE PRIVILEGE
• Treating her like a servant • Making all the big decisions • Acting like the "master of the castle" • Being the one to define men's and women's roles

USING ISOLATION
• Controlling what she does, who she sees and talks to, what she reads, where she goes • Limiting her outside involvement • Using jealousy to justify actions

USING CHILDREN
• Making her feel guilty about the children • Using the children to relay messages • Using visitation to harass her * Threatening to take the children away

MINIMIZING, DENYING AND BLAMING
• Making light of the abuse and not taking her concerns about it seriously • Saying the abuse didn't happen • Shifting responsibility for abusive behavior • Saying she caused it

PHYSICAL · SEXUAL

VIOLENCE

Another model that has more recently been introduced is based on a program started by Men Stopping Violence (MSV), which was developed under the leadership of MSV founding Executive Director Kathleen Carlin and current Executive Director Shelley Serdahely. Emerge! in Tucson operates a program, Men's Education Project, based on the MSV model. MSV believes that an analysis of the interconnection of multiple forms of oppressions is critical to ending violence against women and girls. This belief informs their practice of building accountability among men and with communities. The knowledge, tools and resources developed by MSV are key in engaging and mobilizing men as catalysts for change, and building collaborative relationships with anti-violence programs and other social justice organizations. This program is relatively new, but is promising in its focus on addressing behaviors and root causes.

Challenges in Arizona's services

Like many social services in Arizona, the biggest challenge is insufficient resources. The programs serving victims of domestic violence are doing life-changing, and in many instances life-saving work, but the demand is greater than they are able to accommodate. Since the recession hit Arizona in 2008, the legislature has reduced services for people who are experiencing poverty, homelessness and abuse.

Additionally, while support exists for services that are meant to address victimization, services that address muliple factors are needed. For example, a victim of domestic violence, in addition to needing a safety plan, an advocate, and maybe an emergency shelter bed for a short period of time, may also need affordable housing, child care assistance, food security, financial assistance, access to quality healthcare, quality education for their children that includes adequate supports for academic achievement, community and social supports and activities.

In terms of addressing those who abuse, there needs to be more research about programs and interventions that work. The Administrative Office of the Courts can set standards for treatment programs, in partnership with the advocacy and counseling communities, by reviewing the options available and researching what is happening in other states.

Currently, programs for batterers are not readily available in all parts of the state, and ability to pay for participation in the program can be a burden even when programs are available.

When survivors have been surveyed about what they want to see happen, many indicate that they want the violence to stop, with counseling for themselves and counseling for the abuser in the top five services they wish they had.[12]

Conclusion

Intimate partner violence is a significant issue in Arizona. It impacts women, men, and children in a myriad of ways, from health issues, to mental health, to developmental and beyond. Service providers in Arizona are doing their best to meet the need, with recent expansions in the types of services being offered leading to more victims and their families being served. There is still much that needs to be done, especially with regards to prevention. There is much that can be done to respond to intimate partner violence and providing peace and a sense of security to families experiencing it.

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[12] *Serving Valley Victims of Domestic Violence: Challenges and Choices*, Bill Hart, Morrison Institute for Public Policy.

SPOTLIGHT ON SUBSTANCE ABUSE

By Rosi Andrade, PhD
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Pregnant and Postpartum Women and Addiction

Background

Women with addictions, specifically pregnant and postpartum women with minor children, are a unique population. Multiple social and cultural beliefs and practices affect how women with addictions navigate social roles as mothers and wage earners, and at times limit opportunities to seek out treatment for themselves and services for their minor children.

In a 2011 Pima County sponsored community survey, both community members and stakeholders responded that out of 14 identified health behaviors, substance use had the greatest impact on the health of residents.[1] Many of the 28.2 percent of the women who do not receive prenatal care are thought to be substance involved.

According to a report by the National Center on Addiction and Substance Abuse in Women Under the Influence, "92% of women in need of treatment for alcohol and drug problems do not receive it. Stigma, shame, and ignorance hide the scope of the problem and the severity of the consequences."[2] This can be particularly true for women who are pregnant and parenting, yet pregnancy can also be a motivator for seeking treatment.[3]

Moreover, compared to men, women become addicted to alcohol, nicotine and illegal and prescription drugs, and in shorter period of time, develop substance-related diseases like lung cancer more quickly, and suffer more severe brain damage from alcohol and drugs like Ecstasy. Data on young mothers indicates that they are more likely than young women to smoke (35.0 vs 20.7 percent), and use marijuana (17.9 vs. 10.0 percent), and are just as likely to have used alcohol (25.3 vs. 24.6 percent).[4]

In order to better understand the needs of substance dependent women with children, the University of Arizona - Southwest Institute for Research on Women (UA-SIROW) held two focus groups in 2011, (1) with mothers currently in substance abuse treatment and (2) with working substance using mothers not in treatment.

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[1] Pima County Community Health Assessment (2011). Prepared for the Pima County Community Health Assessment Task Force Meeting. Tucson, AZ. April 8, 2011.
[2] National Center on Addiction and Substance Abuse. (2006). *Women Under the Influence*. Columbia University.
[3] Stevens, S. (2010). *Addressing Risk Behaviors of Drug Involved Women: A Gendered Perspective*. Southwest Interdisciplinary Research Center 8th Annual Research Conference, Phoenix, AZ. April 23, 2010.
[4] Office of Applied Statistics (2011). *Substance Abuse among Young Mothers*.

The focus group findings noted that:

- Women were apprehensive about seeking residential treatment. Even though they knew that they needed treatment services, women continued using drugs until they hit bottom.
- Women did not enter residential treatment because they did not want to lose their job; one of the only positive aspects of their lives.
- Women were also apprehensive about leaving their children with others and feared that they would be reported to Child Protective Services if they enrolled in residential substance abuse treatment.

Mothers shared that contributing factors to their drug addiction and increased use were often related to the stress of holding a job, caring for children (including identifying/paying for childcare), and paying bills. The increased drug use caused additional problems at work leading to tardiness or absenteeism, falling asleep on the job, poor quality of work, and not caring about the work; eventually leading to losing the job or resigning to avoid drug screening. At least half of the women had held the same jobs for long periods of time. Losing a job because of drug use and other stressors, noted a focus group participant, "creates a downward spiral, not only for us as parents, but for kids as well."

Women with addictions, however, recognize the impact of their addiction on their children. When asked how residential drug treatment programs could meet the needs of women and their children, they had several suggestions. Women thought a treatment program should provide transportation and have different types of counseling related to behavior/anger management, working on the self, and furthering of one's education.

Personal Insights:

In focus groups, women with addictions questioned the ability of current residential drug treatment programs to meet the needs of mothers and children. Specifically, where programs are not prepared to receive their children beyond providing housing and food.

- "There needs to be formal daycare and recreational activities," women emphasized.
- "Kids should have a class or program with structured activities and skilled babysitters."
- "So that women can focus on drug treatment, and kids focus on their issues (i.e., trust, safety, behaviors); changing their way of life."

Childcare Needs

Data from 2008 shows that Arizona was classified as being in the top (worse) category for not meeting the needs of persons 12 and older with illicit drug dependence,[5] and the 2009 Arizona State profile shows that only 6.3 percent of all (outpatient and inpatient) substance abuse treatment facilities provide childcare for their clients' children.[6] Childcare and services for both women and children is a critical problem for pregnant and parenting women in need of substance abuse treatment. Moreover, in Arizona almost one third of adults have used illegal drugs in their lifetime with geographical differences

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[5] Substance Abuse and Mental Health Services Administration (2011). *National Survey of Substance Abuse Treatment Services*. Retrieved May 30, 2011 from: http://www.samhsa.gov/data
[6] Office of Applied Statistics (2011). *Substance Abuse among Young Mothers*.

in rates of use (tobacco, alcohol, illegal drugs, misuse of prescription drugs) highlighting implications for addressing local needs.[7] Chambers, Hughes, Meltzer, et al. (2005) found that speaking English and acculturation were significant predictors of increased alcohol use among low-income Latinas.[8] This suggests that the factors reinforcing alcohol consumption in Latinas' early pregnancy need to be better understood and addressed through interventions.

Substance Use, PTSD, Trauma and Mental Health

Najavits (2004) writes that Post-traumatic Stress Disorder (PTSD), "the psychiatric disorder most directly related to trauma, is highly associated with SUD [Substance Use Disorder]."[9] However, it continues to be the case that, "most SUD patients are not adequately assessed for PTSD nor given treatment for it."[10] About 61 percent of men and 51 percent of women will experience at least one traumatic experience in their lifetime.[11,12] Najavits notes that for many patients with SUD, learning about the PTSD diagnosis allows them to view their addiction in a new light, as a way to cope with overwhelming emotional pain; particularly as the PTSD usually occurs first.[13,14,15] Najavits et al. suggest that 30-59 percent of women with SUD suffer PTSD, precipitated by childhood physical or sexual abuse, with the likelihood that women who are survivors of child sexual abuse will be at risk for sexual re-victimization in adulthood.[16,17,18] Further, a study of cumulative experiences of trauma and stress of women enduring extreme poverty, addiction, incarceration, loss of parental rights, and domestic violence, points to women's social location and their identities and predicts that PTSD is likely to increase by 40 percent with each traumatic experience brought on by these stressors.[19]

Data show that younger persons (age 18 to 25) have a higher prevalence of serious mental illness in the past year (7.3 percent); as do women (6.3 percent) versus men (3.2 percent).[20] And likewise, in Arizona

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[7] Arizona State University, Southwest Interdisciplinary Research Center (2010). *Adult Substance Abuse in Arizona*, Phoenix, AZ.

[8] Chambers, C.D., Hughes, S., Meltzer, S.B., et al. (2005). *Alcohol Consumption among Low-Income Pregnant Latinas*. Alcohol Clin Exp Res 11(29): 2022-2028.

[9] Najavits, L.M. (2004). *Assessment of Trauma, Posttraumatic Stress Disorder and Substance Use Disorder: A Practical Guide*. In Wilson, J.P. and Keane, T. (Eds.), Assessing psychological trauma and posttraumatic stress disorder (2nd ed.,):466-491). New York, NY: Guilford Press.

[10] Ibid.

[11] Kubiak, S.P., (2005). *Trauma and Cumulative Adversity in Women of a Disadvantaged Social Location*. Am J Orthopsychiatry Vol. 75, 4:451-46.

[12] Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., and Nelson, C.B. (1995). *Posttraumatic Stress Disorder in the National Comorbidity Survey*. Arch Gen Psychiatry 52:1048-1060.

[13] Najavits, L.M. (2004). *Assessment of Trauma, Posttraumatic Stress Disorder and Substance Use Disorder: A Practical Guide*. In Wilson, J.P. and Keane, T. (Eds.), Assessing psychological trauma and posttraumatic stress disorder (2nd ed.,):466-491). New York, NY: Guilford Press.

[14] Jacobsen, L.K., Southwick, S.M., & Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry*, 158: 1184-1190.

[15] Najavits, L.M., Weiss, R.D., and Shaw, S.R. (1997). *The Link Between Substance Abuse and Posttraumatic Stress Disorder in Women*. Am J Addictions 6:273-283.

[16] Ibid.

[17] Messman-Moore, T.L.& Long, P.J. (2003). *The role of childhood sexual abuse sequelae in the sexual Revictimization of women*. An empirical review and theoretical reformulation. Clinical Psychology Review 23:537-571.

[18] Messman, T. L., & Long, P. J. (1996). *Child sexual abuse and its relationship to revictimization in adult women: a review*. Clinical Psychology Review, 16(5): 397-420.

[19] Kubiak (2005).

[20] National Survey on Drug Use and Health (2011). *2008 Data on Illicit Drug Unmet Needs 12 Years and Older*. Retrieved from: https://nsduhweb.rti.org/respweb/homepage.cfm

women report more mental health conditions than men (20 percent vs.14 percent).[21] Alcohol and drugs and mental health problems are often co-occurring and there exists a higher percent of women with co-occurring disorders compared to men.[22,23] Mental health issues can be particularly troubling for women who are both pregnant, newly postpartum, and specifically among substance abusing women. Importantly, women should be screened and treated for depression during pregnancy and for postpartum depression, an under-diagnosed disorder.[24]

Key Points

- Pregnant and postpartum women with substance abuse addictions are a hidden population, struggling to maintain important aspects of their lives tied to family and work.
- Though pregnant and postpartum women may recognize the need for substance abuse treatment, they often continue drug use until they "hit bottom."
- Pregnant and postpartum women fear that they would be reported to Child Protective Services should they enter substance abuse treatment or receive pre/postnatal care.

Conclusion

The condition of pregnant and postpartum women with addictions and their children calls for changes in treatment services. Specifically, programming that takes into account the unique conditions of gender and cultural roles for women and the dynamics of addiction, including histories of trauma and clinical and social services for women and their children while in treatment, aftercare, and recovery in the community.

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[21] Stevens, S., Andrade, R.A.C., and Ruiz, B.S. (2009). *Women and Substance Abuse: Gender, Age and Cultural Considerations*. Journal of Ethnicity in Substance Abuse, 8, 341-358.
[22] Ibid.
[23] Stevens, S.J. and Wexler, H.K. (Eds.) (1998). Drugs & Society, 13 (1/2). *Women and Substance Abuse: Gender Transparency*. Binghampton, NY. The Haworth Press.
[24] Substance Abuse and Mental Health Services Administration (2009). *Substance Abuse Treatment: Addressing the Specific Needs of Women - A Treatment Improvement Protocol TIP 51*. Rockville, MD

SPOTLIGHT ON CHILDREN WITH DISABILITIES AND THEIR FAMILIES

By Maureen Russell, PhD, OTR/L
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Many Arizona parents who have a child with a disability report that cost is an obstacle to their child's participation in community activities. Additionally, families report that stigma or negative reactions to their child in the community sometimes influences the family's decision to forego activities.[1]

Disability places a child at additional risk for child maltreatment. Children with behavior problems are more at risk for physical abuse because parents may become more easily stressed by their child's demands. Children who do not speak are more likely to experience sexual abuse.[2] In 2013, 30 percent of the children in the Arizona Division of Child Safety system had a disability.[3]

Mothers who have children with developmental disabilities are at increased risk for higher levels of stress, poor sleep quality, and depression due to greater caregiving responsibilities.[4]

The two primary systems that serve children with disabilities and their families are the Exceptional Student Services (ESS) through the Arizona Department of Education (ADE) and the Division of Developmental Disabilities (DDD) through the Arizona Department of Economic Security. ESS and DDD have different criteria to qualify children for services.

To qualify for special education under ESS, the disability must have an adverse effect on the child's educational performance and require specially designed instruction in order for the child to access and make progress in the general education curriculum. In 2014, 11.6 percent of children in Arizona ages 5-21 were identified as having a disability under the Individuals with Disabilities Education Act (IDEA), the federal legislation that guarantees all children a free and appropriate education.[5]

Inclusion in the general education program has benefits for children with and without disabilities. It is an opportunity to build friendships, develop respect for others, and learn from peer models. In spite of these benefits, over one third of the students with disabilities were included in the general education

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[1] The National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. (2018, January). *National Core Indicators: 2016-17 Child Family Survey, Arizona Report*. Retrieved from: https://www.nationalcoreindicators.org/upload/core-indicators/AZ_CFS_edits.pdf
[2] Center for Disease Control and Prevention. (2018) *Childhood Maltreatment among Children with Disabilities*, Retrieved from: https://www.cdc.gov/ncbddd/disabilityandsafety/abuse.html
[3] McFadden, E.S., Fisher, K.W., Lee, S.E., Kovacs, M., & Barajas, M. (2016, January). *Comprehensive Review and Analysis, 2nd ed. Arizona's Services, Supports, and Unmet Needs for Individuals with Developmental Disabilities and their Families*. Prepared for the Arizona Developmental Disabilities Planning Council.
[4] Lee, J. (2013). Maternal stress, well-being, and impaired sleep in mothers of children with developmental disabilities: A literature review. *Research in Developmental Disabilities*, 34, 4255-4273.
[5] Arizona Department of Education. (2018). *Exceptional Student Services*, Retrieved from: http://www.azed.gov/specialeducation/disability-categories/

program with their peers for less than 80% of the school day.[6]

Children who are 3 to 5 years old and have a disability are served in school district preschool programs through Part B of the IDEA. Babies and toddlers with disabilities are served in home-based programs through Part C of IDEA administered by the Arizona Early Intervention Program (AzEIP).

School districts, particularly in rural areas of Arizona, have difficulty hiring and retaining qualified special education teachers and related services professionals.[7] Students who are medically fragile or who have chronic health conditions may be put at risk when schools cut nursing services due to financial constraints.[8]

To qualify for DDD an individual must have a diagnosis (cerebral palsy, intellectual/cognitive disability, autism, epilepsy) that results in functional limitations in three or more life skills. DDD serves approximately 36,000 children and adults with developmental disabilities statewide acting as a managed care organization and delivering services such as respite,[9] habilitation, and therapies through a large network of providers.[10]

Although 85% of the families reported that their child's DDD service plan included all the services and supports their child needed, only 65% reported actually getting these services. Almost all families that received the needed services and supports reported that this made a positive difference in the life of their family and improved their ability to care for their child.[11]

A barrier to receiving needed services through DDD is the availability of qualified personnel. Direct support agencies that train and hire respite providers reported an annual turnover rate of almost half of their employees.[12] Agencies that contract with DDD struggle to pay respite providers a living wage and keep pace with changes in the state minimum wage laws.[13] There is also a shortage of Occupational Therapists, Physical Therapists, and Speech Therapists to provide home and community based therapies through DDD.

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[6] OSEP Office of Special Education Programs. (n.d.) *GRADS 360 Site, State Performance Plan/Annual Performance Report, Indicator 5: Educational Environments (Children 6-21)*. Retrieved from: https://osep.grads360.org/#report/apr/2016B/Indicator5/HistoricalData?state=AZ&ispublic=true

[7] Arizona Department of Education, Educator Retention and Recruitment Task Force. (2015, January). *Educator Retention and Recruitment Report*. Retrieved from: https://www.azed.gov/wp-content/uploads/2015/02/err-initial-report-final.pdf

[8] Arizona Department of Education, Diane Douglas, Superintendent of Public Instruction. (2018). *AZ Kids Can't Wait: A Comprehensive Plan to Improve Arizona's Education System*. Retrieved from: https://cms.azed.gov

[9] Planned care for an individual with special needs that provides temporary relief to family caregivers. Source: *Access to Respite Care and Help*. (n.d.). ARCH Home. Retrieved from: https://archrespite.org/

[10] Arizona Department of Economic Security. (2018). *Division of Developmental Disabilities*. Retrieved from: https://des.az.gov/services/disabilities/developmental-disabilities

[11] The National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. (2018, January). *National Core Indicators: 2016-17 Child Family Survey, Arizona Report*. Retrieved from: https://www.nationalcoreindicators.org/upload/core-indicators/AZ_CFS_edits.pdf

[12] The National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. (2018, January). *National Core Indicators: 2016 Staff Stability Survey Report*. Retrieved from: https://www.nationalcoreindicators.org/indicators/domain/staff-stability/staff-stability/

[13] Duda, J. (2018, October 8) Developmental disabilities service providers say state funding for minimum wage increase lagging. *Arizona Mirror*, Retrieved from: https://www.azmirror.com/2018/10/08/developmental-disabilities-service-providers-say-state-funding-for-minimum-wage-increase-lagging/

SPOTLIGHT ON AMERICAN INDIANS IN ARIZONA

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Of the 7.17 million people living in Arizona, 5.3 percent (308,097) self-identify as American Indian or Alaskan Native only, (AI/AN), ranking it the state with the third highest number of AI/AN residents.[1] Twenty-one federally recognized tribes reside in Arizona.[2]

In this chapter we present health data for infants, children, adolescents, adults and the elderly and culturally relevant interventions and public health programs that serve them. We provide a snapshot of the health of Arizona AI/AN and the programs that promote healthy families and thriving children. Because many AI/AN households are multi-generational we present a perspective across the lifespan and include special concerns such as that of murdered and missing Indigenous women and girls that currently impacts Arizona.

The collection and reporting of health data for American Indians and Alaska Natives is a complicated and complex issue. Often data is incomplete due to issues in misclassification, under-reporting and aggregation of data.[3] It is important to consider the source of the data and how it was collected. For example, medical records exclude the population that does not utilize that health resource; information that is collected by phone may exclude those in lower income brackets who cannot afford a phone; surveys may not ask questions in a culturally competent manner. How identity is determined can also be problematic, people may self-identify as AI/AN but not be an official member of a tribe.

Critical Health Disparities in Arizona AI/AN Health Across the Lifespan

Key health disparities exist between Arizona's AI population when compared to the non-Hispanic white or "All Races" rates of morbidity and mortality. Overall, compared to all groups in Arizona, AI mortality rates are dramatically disproportionate in four key areas, unintentional injuries, assaults, motor vehicle accidents, and alcohol: (1) three times higher for unintentional injuries (139.0 v. 48.1), (2) assaults (15.7 v. 5.6), (3) more than four times higher due to motor vehicle accidents (54.3 v. 12.6), and (4) more than six

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[1] *Quickfacts Arizona.* [cited 2019 April 10]; Retrieved from: https://http://www.census.gov/quickfacts/az
[2] *Federal and State Recognized Tribes.* 2018 [cited 2019 April 22]; Retrieved from: http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx
[3] Satter, D.E., Randall, L.L., and Solomon, A.T., *The Complexity of American Indian and Alaska Native Health and Health Reserach: Historical, Social, and Political Implications for Research, in Conducting Health Research with Native American Communities*, T.A.a.R. Solomon, L.L, Editor. 2014, APHA Press: Washington, D.C.

times higher due to alcohol (111.5 v. 17.5).[4] Significant disparities exist for premature mortality across the lifespan for AI when compared to all groups in Arizona, with rates three times as high among children age 1-14 (50.3 v. 15.4), twice as high among 15-19 year old youth (97.1 v. 47.5), almost three times as high among 20-44 year old adults (423.9 v. 146.6), and almost twice as high among those between the ages of 45-64 (1108.3 v. 641.0).[5]

Table 1. Comparison of Mortality in Arizona between AZ AI and State Average per 1,000 for infants and 100,000 for children, youth and adults, 2017.

	Mortality	
	State Average	**AI Average**
Infant	5.6	9.5
Neonatal	3.5	4.1
Postneonatal	2.1	5.3
Children and Youth		
Ages 1-14	18.2	39.2
Ages 15-19	53.7	174.4
Adult	679.3	1001.9

Data Source: Health Status Profile of American Indians in Arizona 2017 Data Book[6]

Maternal Health

The health of women during pregnancy can impact the health of the mother but also can influence the health of the child as well. Teen pregnancy rates for AI/AN are almost double that of the average rate for other Arizonans (27.3 v. 14.1/1000 for 15-17 yrs. and 90.8 v. 58.4/1000 for 18-19 yrs. old).[7] American Indian pregnant women in Arizona have been found to use less tobacco than the rest of the AZ population (3.4 vs 4.7 per 100).[8] However, AI women in Arizona experience higher incidence rates per 100 than the rest of the AZ population for no prenatal care (4.1 vs 2.9), gestational hypertension (11.2 vs 6.7), gestational diabetes (14.8 vs 7.7), and slightly more "gestational weight gain-excessive" (46.5 vs 46.2).[9]

Infants

Health disparities for AI infants include low birth weight, premature births and Sudden Infant Death Syndrome (SIDS). In 2017, there were a total of 4,870 American Indian children born, 160 fewer than the 5,030 births in 2016.[10] While fewer Arizona AI infants need intensive care than the average rate for Arizona (6.5 vs. 7.1/1,000), rates for SIDS are twice as high (0.4 vs. 0.2).[11] Higher incidence rates for Arizona in 2017

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[4] *Arizona American Indian Health Status Summary Report for Data Year 2015,* 2017, Arizona Department of Health Services.
[5] Ibid.
[6] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book*, 2017, Arizona Department of Health Services.
[7] *Arizona American Indian Health Status Summary Report for Data Year 2015,* 2017, Arizona Department of Health Services.
[8] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book*, 2017, Arizona Department of Health Services.
[9] Ibid.
[10] Ibid.
[11] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book,* 2017, Arizona Department of Health Services.

include mortality rates for AI infants compared to all of Arizona and born too small or premature (low birth weight 7.7 vs. 7.5/1,000; preterm 10.9 vs. 9.3).[12]

Children/Youth

Higher mortality rates for AI children ages 1-14 are due to multiple issues. Suicide is a critical issue for AI nationwide and in Arizona as well. The problem is particularly damaging to communities when the victims are young. Almost double the percentage of AI/AN in Arizona (19 percent) reported a suicide attempt versus 10 percent of other races in Arizona.[13] A higher percentage of AI/AN youth binge drink compared to other racial groups in Arizona (12 percent v. 19 percent).[14] Alcohol abuse is a concern for adolescents for multiple reasons including high morbidity and mortality rates from accidents and injuries, and even liver cirrhosis among AI/AN adults.

Adults

American Indian men die 19 years younger, and AI women die 11 years younger than other Arizonans (median age 76).[15] Heart Disease, accidents, cancer, diabetes, chronic liver disease and cirrhosis are the leading causes of AI mortality in Arizona.[16] The leading causes of death for AI men are consistent with the all Arizona rates but for AI women, cancer is the leading cause of death, heart disease the second and accidents are the third leading cause.[17]

Table 2. Five Leading Causes of Death by Gender among American Indians (2015)

Rank	Female	Male	Combined
1	Cancer 112.4	Accidents (unintentional injury) 203.9	Accidents (unintentional injury) 139.0
2	Diseases of the heart 89.1	Diseases of the heart 158.9	Cancer 124.4
3	Accidents (unintentional injury) 82.7	Cancer 142.1	Diseases of the heart 119.1
4	Chronic liver disease & cirrhosis 66.1	Chronic liver disease & cirrhosis 91.8	Chronic liver disease & cirrhosis 77.6
5	Diabetes 65.3	Diabetes 85.6	Diabetes 73.9

Number of deaths per 100,000 population age-adjusted to the 2000 U.S. standard.[18]

Data Source: *Health Status Profile of American Indians in Arizona 2015 Data Book.*

[12] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book,* 2017, Arizona Department of Health Services.
[13] Cunningham, J.K., T.A. Solomon, and M.L. Muramoto, *Alcohol use among Native Americans compared to whites: Examining the veracity of the 'Native American elevated alcohol consumption' belief*. Drug Alcohol Depend, 2016. 160: p. 65-75.
[14] Ibid.
[15] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book,* 2017, Arizona Department of Health Services.
[16] Ibid.
[17] Ibid.
[18] Find Health Care. [cited 2019 April 10]; Retrieved from: https://http://www.ihs.gov/findhealthcare/?CFID=140528741&CFTOKEN=63832242

Twenty-one percent (21 percent) of AI/AN in Arizona report drinking alcohol.[19] While the Arizona State Division of Health (2016) attributes high mortality rates from several diseases related to alcohol use, recent published data has found that AI/AN alcohol use rates nationally are comparable to those of non-Hispanic Whites (NHW), and that 59.5 percent of AI/AN report alcohol abstinence compared to 43.1 percent of NHW.[20] It also has been found that living on a reservation can be a protective factor for alcohol consumption.[21] Similarly for smoking, cigarette use has been found to be lowest nationally among AI/AN living on tribal lands.[22] Percentages of smokers in Arizona are the lowest for AI/AN (12.8 percent) than any other race in Arizona.[23]

Elders and Other Family Members

A complete look at the AI/AN family unit includes extended family living in the same household such as grandparents who may be the sole caregiver for a grandchild. Nationally 7.6 percent of AI/AN live with grandchildren and of these, more than half are responsible for raising them, as the primary guardian (51.1 percent).[24] In Arizona, 13 percent of AI/AN grandparents are the primary guardians, responsible for caring for grandchildren, almost twice the national percentage.[25] AI/AN elders may be providing care to their families but, they may also be in need of caregiving for cancer, chronic disease, and/or for frailty due to aging. In 2015, approximately 18 percent of the U.S. population report being an unpaid caregiver to someone in their family.[26] This survey, unfortunately, did not include AI respondents. In Arizona, 8.3 percent of the population reports as family caregivers.[27] Data on family caregivers in Arizona is limited, however, a recent study showed that approximately 20 percent of members of an Arizona tribe are family caregivers.[28] Respondents reported that they held a personal desire to take care of their elder family member and a cultural expectation to do so, was the main reason for being a caregiver.[29] Caregivers performed various duties and 43 percent reported receiving additional help caregiving from a family member under the age of 18, displaying multi-generations involved in family caregiving.[30] Caregivers worked longer hours, almost double the national percentage of caregivers providing more than 40

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[19] *Behavioral Health and Substance Abuse Among American Indians in Arizona, Nevada and Utah*, 2018, Inter Tribal Council of Arizona (ITCA), Epidemiology Center.

[20] Cunningham, J.K., T.A. Solomon, and M.L. Muramoto, *Alcohol use among Native Americans compared to whites: Examining the veracity of the 'Native American elevated alcohol consumption' belief*. Drug Alcohol Depend, 2016. 160: p. 65-75.

[21] Ibid.

[22] Cunningham, J.K., Ritchey, J., Solomon, T.A., and Cordova-Marks, F.M., *Cigarette use among American Indians and Alaska Natives in Metropolitan areas, rural areas, and Tribal lands*. Journal of Public Health Practice and Management., In Press.

[23] Annual Report, Smoking in Arizona 2018. Retrieved from: https://http://www.americashealthrankings.org/explore/annual/measure/Smoking/state/AZ

[24] *Indian Health Services, Adolescent Treatment Centers.* [cited 2019 April 20]; Retrieved from: https://http://www.ihs.gov/phoenix/adolescenttreatmentcenters/

[25] *Grandfacts, State fact sheets for grandparents and other relatives raising children.* 2019 [cited 2019 April 18]; Retrieved from: https://http://www.aarp.org/content/dam/aarp/relationships/friends-family/grandfacts/grandfacts-arizona.pdf

[26] *Federal and State Recognized Tribes.* 2018 [cited 2019 April 22]; Retrieved from: http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx

[27] *State of the States in Family Caregiver Support, Arizona State Profile.* [cited 2019 April 17]; Retrieved from: https://www.caregiver.org/caregiving-across-states-50-state-profiles-2014

[28] Cordova, F.M., et al., *Caregiving on the Hopi Reservation: Findings from the 2012 Hopi Survey of Cancer and Chronic Disease.* J Community Health, 2016. 41(6): p. 1177-1186.

[29] Cordova-Marks, F.M., et al., *Characteristics of American Indian Female Caregivers on a Southwest American Indian Reservation.* J Community Health, 2019. 44(1): p. 52-60.

[30] Ibid.

hours/week (43 percent vs 23 percent).[31] They also reported being a caregiver for more years than the national average (5.5 vs. 4 years).[32] While they reported that they have stress, it was also found that increasing levels of resilience in caregivers decreased stress.[33] Half of the caregivers reported having "high resilience" levels and few caregivers were classified as "low resilience."[34]

Access to Healthcare

American Indians and Alaska Natives in Arizona can utilize Indian Health Services (IHS), Arizona's Medicaid-Arizona Health Care Cost Containment System (AHCCCS), and private insurance to access healthcare. However, in 2015, 25 percent of AI/AN children and 28 percent of AI/AN adults in the United States reported being uninsured; 35 percent of AI/AN adults reported insurance coverage through AHCCCS.[35] The three most common sources of payment for labor and delivery services in 2017 for AI/AN in Arizona included AHCCCS (68 percent), IHS (16.8 percent), and private insurance (12.9 percent).[36]

Arizona is home to three IHS Areas, with Area Headquarters located in Phoenix, Tucson and on the Navajo reservation. The Phoenix Area has 10 IHS health facilities, Tucson has five, and 6 are located on the Navajo reservation, and 23 IHS tribally operated 638 programs/clinics are located in Arizona.[37] These IHS facilities have locations in urban areas and on reservations in Arizona and offer a variety of services. Dental clinics are located at 15 of the IHS facilities, 11 facilities are classified as Hospitals, and there are three behavioral health centers located in Whiteriver, Parker and Sacaton.[38]

In Arizona, 79.05% of AI/AN were insured, and 20.95% were uninsured in 2017. "Health insurance coverage for these percentages includes: employer/union based insurance, insurance purchased directly, TRICARE/other military insurance, medicare, Medicaid/other government assistance, or VA. Persons with only Indian Health Services coverage are not considered to be insured because such coverage is not always comprehensive." In 2017, the percengages of AZ AI/AN covered with public insurance was 49.76%, private insurance was 34.02%, with 15.8% having only IHS coverage.[39,40]

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[31] Cordova-Marks, F.M., et al., *Characteristics of American Indian Female Caregivers on a Southwest American Indian Reservation*. J Community Health, 2019. 44(1): p. 52-60.
[32] Ibid.
[33] Cordova-Marks, F.M., *Hopi Adult Caregiver Survey*, 2018.
[34] Ibid.
[35] Alker, J., Wagnerman, K., and Schneider, A. , *Coverage trends for American Indian and Alaska Native Children and Families,* 2017, Georgetown University Policy Instittue.
[36] Kemp, M.L.S., and Huang, Y. , *Health Status Profile of American Indians in Arizona 2017 Data Book*, 2017, Arizona Department of Health Services.
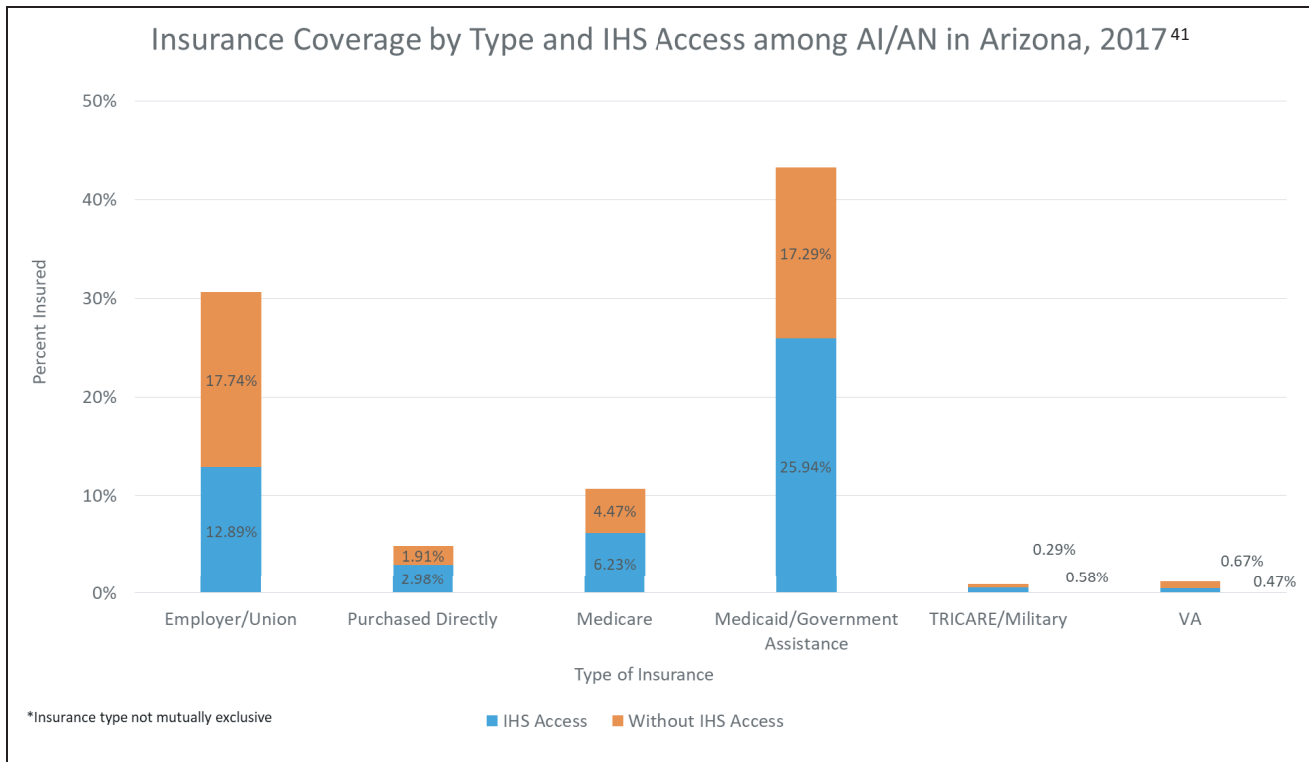[37] *Find Health Care*. [cited 2019 April 10]; Retrieved from: https://http://www.ihs.gov/findhealthcare/?CFID=140528741& CFTOKEN=63832242
[38] Ibid.
[39] Source: US Census – 2017 ACS 1-year Public Use Microdata Samples (PUMS) https://factfinder.census.gov/faces/ tableservices/jsf/pages/productview.xhtml?pid=ACS_pums_csv_2017&prodType=document
[40] J., Ritchey, F. Cordova-Marks, E.Gottlieb., Personal Communication. May 17, 2019.

Table 3. Insurance by Type, 2017

Insurance Coverage by Type and IHS Access among AI/AN in Arizona, 2017[41]

*Insurance type not mutually exclusive
■ IHS Access ■ Without IHS Access

[41] J., Ritchey, F. Cordova-Marks, E.Gottlieb., Personal Communication. May 17, 2019.
Data Source: Population Division, U.S. Census Bureau. Data presented for 2010 through 2017 are Vintage 2017 population estimates. Each year the U.S. Census Bureau revises their post-2010 estimates. Therefore, data presented here may differ from previously published estimates. Figures for 2010 represent revised population estimates for July 1, 2010 - not actual Census counts from April 1, 2010.

Programs to Strengthen Families in Arizona

Health from a Cultural Perspective

Tribes and Indigenous people believe that AI/AN health concerns, health prevention, screening and treatment should be viewed through a cultural lens. The American Indian and Alaska Native Cultural Wisdom Declaration (CWD) adopted by multiple tribes and tribal organizations, is published in the National Tribal Behavioral Health Agenda and the National Tribal Public Health Agenda.[42] The CWD states "We know our Native ways are effective. We know that these ways are different from the Western worldview. We know we are experts in practicing and implementing our traditional ways to enhance the health of our people."[43] Programs that are narrowly focused and are community driven or employ community resources have been found to be effective in improving the health of Indigenous people.[44]

Some examples of Arizona programs to address AI/AN health issues by including cultural programming influenced by cultural wisdom:

[42] The National Tribal Behavioral Health Agenda, American Indian and Alaska Native Cultural Wisdom Declaration, 2019, Substance Abuse and Mental Health Service Administration.
[43] Ibid.
[44] Geana, M.V., et al., Improving Health Promotion to American Indians in the Midwest United States: Preferred Sources of Health Information and Its Use for the Medical Encounter. J Community Health, 2012. 37(6): p. 1253-63.

Suicide prevention:
- Native Americans for Community Action, Inc.[45]
- Navajo IHS- Iiná Ayóó'ííní'ní, (Love Your Life) campaign[46]

Drug prevention, cessation and treatment:
- Desert Visions Youth Wellness Center[47]
- Holistic Wellness Counseling and Consultation Services[48]
- Tucson Indian Center-White Bison Sobriety Group[49]
- Native Americans for Community Action, Inc.[50]
- Phoenix Indian Center-Living in 2 Worlds Program[51]

Cancer prevention, screening, support:
- Hopi Office of Cancer Support Services[52]
- Tohono O'odham Cancer Prevention Program[53]

Diabetes screening, prevention or treatment:
- Hopi Wellness Center[54]
- Navajo Nation Special Diabetes Program[55]
- Pascua Yaqui Diabetes Prevention and Treatment Program[56]

Tobacco use prevention, cessation:
- Hopi Office of Cancer Support Services-Tobacco Program[57]

Strengthening families:
- Phoenix Indian Center-Parenting in 2 Worlds Program[58]

[45] *Behavioral Health Services for Everyone*. Retrieved from: http://www.nacainc.org/behavioral-health.html
[46] *IHS Navajo Area Launches Navajo-and English Suicide Prevention Multimedia Campaign*. 2016 [cited 2019 April 22]; Retrieved from: https://http://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/NavajoAreaSuicidePreventionCampaign.pdf
[47] *Indian Health Services, Adolescent Treatment Centers*. [cited 2019 April 20]; Retrieved from: https://http://www.ihs.gov/phoenix/adolescenttreatmentcenters/
[48] *Hollistic Wellness and Consultant Services, Our Mission*. [cited 2019 April 15]; Retrieved from: https://http://www.hwccsonline.com/default.html
[49] *Events, White Bison Recovery Group*. [cited 2019 April 15]; Retrieved from: http://www.ticenter.org
[50] *Behavioral Health Services for Everyone*. Retrieved from: http://www.nacainc.org/behavioral-health.html
[51] *Living in 2 Worlds*. [cited 2019 April 12]; Retrieved from: https://phxindcenter.org/
[52] Joshweseoma, L., F.M. Cordova-Marks, Editor 2019.
[53] *Cancer Prevention Program*. [cited 2019 April 14]; Retrieved from: http://www.tonation-nsn.gov/health-human-services/community-health-services/cancer-prevention-program/
[54] Joshweseoma, L., F.M. Cordova-Marks, Editor 2019.
[55] *Navajo Nation Special Diabetes Project*. [cited 2019 April 15]; Retrieved from: http://www.nnsdp.org/About_Us.aspx
[56] *About the Diabetes and Prevention Program*. [cited 2019 April 11]; Retrieved from: https://http://www.pascuayaqui-nsn.gov/index.php/diabetes-prevention-treatment-program
[57] Joshweseoma, L., F.M. Cordova-Marks, Editor 2019.
[58] *Parenting in 2 Worlds*. [cited 2019 April 12]; Retrieved from: https://phxindcenter.com/prevention-services/parenting-in-2-worlds/

Policies and Laws that Make a Difference

The American Indian Child Welfare Act

American Indian and Alaska Native children are often pulled into foster care by social workers who remove children from their homes before exhausting all familial and tribal opportunities for placement. The harmful effects of alienating AI/AN children from their communities, families, and cultural identities are important to child and family wellbeing.[59] In 1978, Congress passed the Indian Child Welfare Act (ICWA) to address the disproportionately high percentage of Native children being placed by public and private entities in non-Native homes especially through fostering and adoption. In the years leading up to the passage of ICWA, research showed that one in four Native children were being removed from their homes and 85 percent were being placed in non-Native homes.[60]

This practice echoed the federal policy of forced assimilation of American Indian children implemented in the late 1800s through government-sanctioned boarding schools. Congress acknowledged the historical and ongoing impact of such separations in its statement of ICWA's policy goals: "to promote the stability and security of Indian tribes and families … [through] placement of [Native] children in foster or adoptive homes which will reflect the unique values of Native culture (25 U.S. Code § 1902)."

ICWA works by giving tribal authorities a legal role in determining where Native children are placed.

ICWA was created to put restrictions and guidelines in place that protect the heritage of Native children as well as their best interests. The legislation has continued to be litigated in state and federal courts, including Arizona. Legal challenges have often involved parties arguing that the Act impermissibly creates a racial preference by requiring Native families to be considered over non-Native families.[61]

Defenders of the act have emphasized the status of tribes as distinct sovereign entities with political relationships with the federal government rather than as merely constituents of a racial category.[62] The challenges notwithstanding, ICWA remains an effective means for tribal, state, and federal governments to ensure that Native children can grow up in environments that best support their interests in becoming healthy and productive members of their communities and broader society.

The Violence Against Women Act and Murdered and Missing Indigenous Women and Girls

The most recent reauthorization of the Violence Against Women Act (VAWA) in 2019 will look further into a critical issue in Arizona of murdered and missing Indigenous women and girls. The Urban Indian Health Institute (UIHI) has estimated that 506 women and girls between the ages of one to 83 from American

[59] *ICWA Talking Points Guide*. 2019 [cited 2019 April 11]; Retrieved from: https://www.nicwa.org/wp-content/uploads/2019/02/2019-02-12-ICWA-Talking-Points-Guide_NICWA-FINAL.pdf

[60] Cross, T.L. *The Indian Child Welfare Act: We Must Still Fight for Our Children*. 2013; Retrieved from: http://www.nrc4tribes.org/news.cfm?a=325

[61] Fischer, H. *Arizona Supreme Court limits right of tribes to intercide in adoption case*. 2017 [cited 2019 April 13]; Retrieved from: https://azcapitoltimes.com/news/2017/06/13/arizona-supreme-court-limits-right-of-tribes-to-intercede-in-adoption-cases/

[62] Baker, B.J. *Louisiana solicitor general "grossly mischaracterized" federal law, letter to the editor*. 2019 [cited 2019 April 15]; Retrieved from: https://http://www.theadvocate.com/baton_rouge/opinion/letters/article_8ca457f0-50c3-11e9-abb5-438ad9076b9b.html

Indian and other Indigenous communities have gone missing or been murdered in the United States.[63] Data from Flagstaff, Phoenix, Tempe and Tucson indicate 54 Indigenous women and girls from Arizona are missing or have been murdered, Arizona is ranked third state in the nation and Tucson was ranked third (tied) among all cities in the nation with 31 cases.[64] Nationally, "The 506 cases identified are likely an under-document of missing and murdered Indigenous women and girls in urban areas" due to the limited number of agencies responding to the UIHI data request.[65] In April of 2019, the Arizona state senate passed legislation authorizing a task force to investigate the problem of murdered and missing Indigenous women and girls in the state;[66] Signed by Governor Doug Ducey May 2019.[67]

In 2015, the VAWA reauthorization of 2013 included the Special Domestic Violence Criminal Jurisdiction, which allowed crimes against AI women committed on tribal lands (including domestic, dating and criminal violence) by tribal and non-tribal members to be investigated, prosecuted, convicted and sentenced by Tribes.[68, 69] Since 2015, 18 tribes in the United States have put this jurisdiction into action, including the Pascua Yaqui Tribe in Arizona.[70]

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[63] *Missing and Murdered Indigenous Women and Girls*, 2018, Urban Indian Health Institute.
[64] Ibid.
[65] Ibid.
[66] Ibid.
[67] Oldham, G. Ducey signs bill into law that will study missing, murdered Indigenous Women. Arizona Republic. Retrieved May 18, 2019 from: https://www.azcentral.com/story/news/politics/legislature/2019/05/14/missing-and-murdered-indigenous-women-bill-signed-into-law/3671997002/
[68] Gibson, E. Arizona Senate Votes to End Task Force on Missing and Murdered Indigenous Women. [cited 2019 April 15]; Retrieved from: https://news.azpm.org/p/news-articles/2019/4/11/149478-arizona-senate-votes-to-form-task-force-on-missing-and-murdered-indigenous-women/
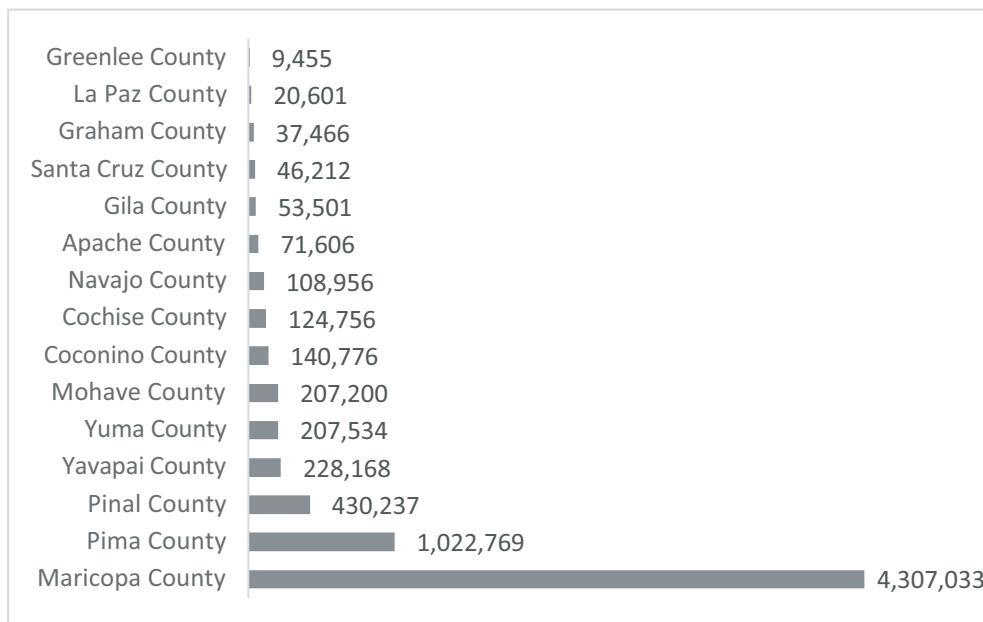[69] *Special Domestic Violence Criminal Jurisdiction*. [cited 2019 April 10]; Retrieved from: http://www.ncai.org/tribal-vawa/sdvcj-overview/faqs
[70] Ibid.

SPOTLIGHT ON FAMILIES IN RURAL ARIZONA

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This chapter explores challenges specific to rural families and service provision in rural Arizona areas. In Arizona, rural counties are sparsely populated, and families are met with large deficits in resources, services, and supports. For example, Greenlee County has a population of 9,455 people as compared to Maricopa County, with 4,307,033. Furthermore, population density for each county (number of people per square mile) illuminates the rurality of most counties in Arizona. For example, La Paz has 4.4 people per square mile compared to Maricopa County, with 333.8 per square mile. For this document, based on population and population density, all Arizona counties are considered rural except Maricopa and Pima Counties. Figures 1 and 2 below show these county-level differences.

Figure 1. Population Estimates by County.

County	Population
Greenlee County	9,455
La Paz County	20,601
Graham County	37,466
Santa Cruz County	46,212
Gila County	53,501
Apache County	71,606
Navajo County	108,956
Cochise County	124,756
Coconino County	140,776
Mohave County	207,200
Yuma County	207,534
Yavapai County	228,168
Pinal County	430,237
Pima County	1,022,769
Maricopa County	4,307,033

Data Source: Population Division, U.S. Census Bureau. 2017 Population Estimates. Data may contain sampling error. Sampling error and margin of error may render some of the differences between geographies statistically insignificant.

Figure 2. Persons by Square Mile by County.
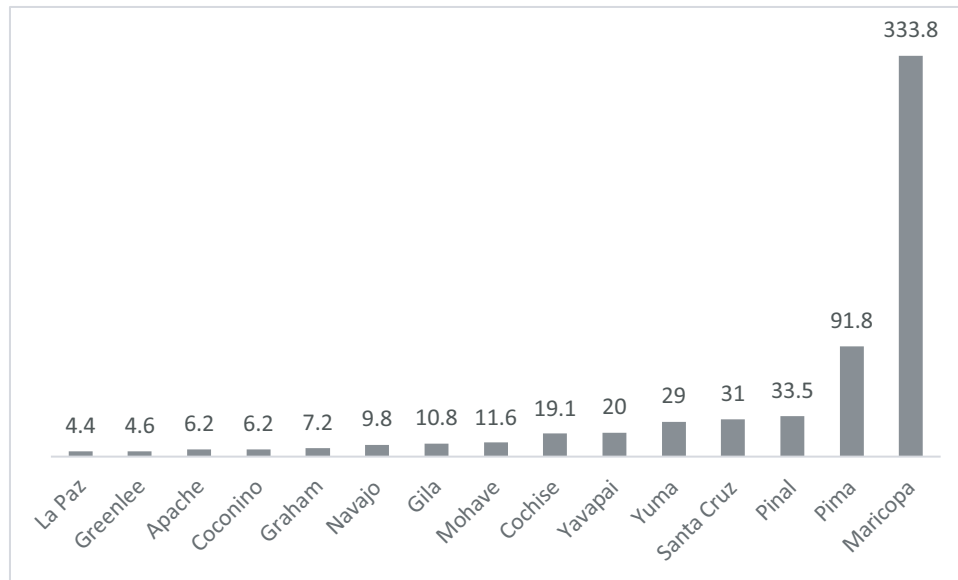

Data Source: Arizona State Data Center, Phoenix

Rural Challenges

Although the average poverty rate in Arizona is 17.7 percent, poverty rates are higher in most of rural Arizona, with 11 of 15 counties experiencing rates of poverty greater than 17.7 percent, and one (Apache County) being more than double the average rate. Figure 3 shows these differences. Opportunities for employment that pay a living wage are scarce, even for the lowest paying jobs. For families who are fortunate enough to find employment at all, they often hold multiple jobs just to make ends meet. This puts a burden on families with children who resort to those same children to babysit or, as one agency director shared, "a boyfriend takes care of the baby." It is not uncommon for individuals to hold part time jobs, making them ineligible for health insurance. Unfortunately, when they are working multiple part time jobs, they don't have time to practice self-care or provide a nurturing environment for children.

Figure 3. Poverty Percentage Rates by County.
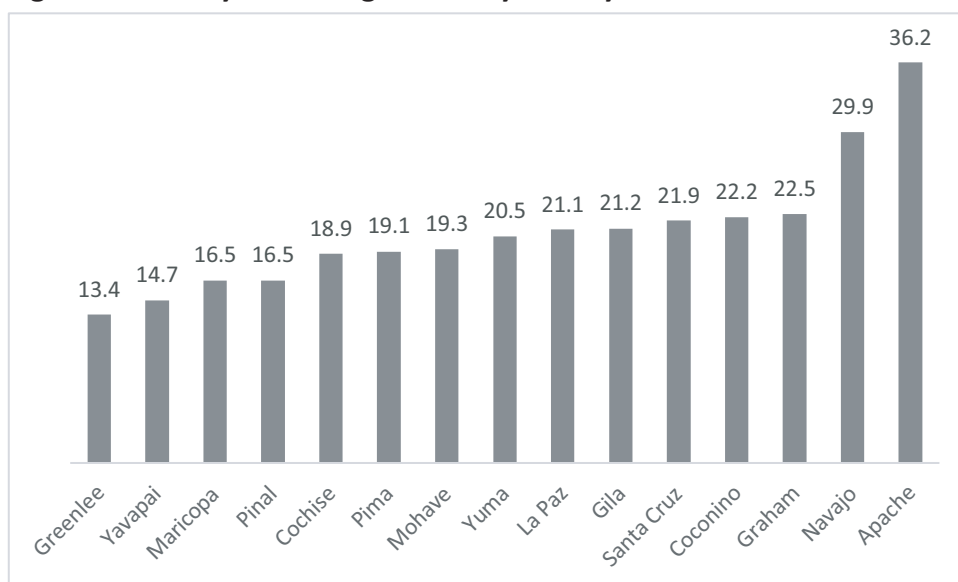
Data Source: Welfareinfo.org, 2019.

In La Paz County, the only available career center closed, so there is no help in locating employment or providing employment skills training for those who are isolated and have never held a job or been on an interview (such as in the case of victims of domestic violence, whose abusers have, by design, fostered their isolation). Even when those living in poverty are actively involved in rebuilding their lives within their community, they have no other option but to accept a bus ticket, uproot their (new) lives, and relocate to a more urban location where employment opportunities are better.

Hunger and Violence

Hunger is an issue in rural Arizona. Even though food banks provide food for anyone who needs it, families in extreme poverty still experience some level of food insecurity. In addition, although many children are eligible for school meal programs, these same children may go hungry after school and during the weekend.

For survivors of violence to achieve their new normal, they work with advocates and case managers to help them find employment, finish school, get a GED, go to medical/dental/behavioral health appointments, court appointments, etc. These endeavors pose a particular challenge for survivors with children. In many rural counties, day care is not available after 6:00 pm or on weekends within a 100-mile radius. There are no after-care programs for youth and teens. In some counties, there is simply no day care available for children under the age of two. As a result, people with low income and survivors who have no day care available resort to unlicensed day care or, with no day care at all, are not able to take the necessary steps to make strides to rebuild their lives.

Distance

Distance is a barrier in rural Arizona, where there are huge stretches of desert, farm country, dirt roads, and as an agency director observed, "feeling of being in the middle of nowhere." One-way travel to critically needed services and supports can take 3-4 hours. For example, to get a Sexual Assault Nurse Exam (SANE), victims of sexual assault in Gila County need to travel all the way to Scottsdale. This often dissuades survivors from getting medical forensic exams, which are necessary for the collection of potential evidence and important for providing sexual assault survivors with medical care. Survivors with intensive behavioral health needs are required to travel 3-4 hours for the nearest substance abuse residential treatment. The long drives are emotionally taxing and discouraging, and often resulting in survivors changing their minds along the way to forego the SANE exam or necessary behavioral health treatment. A rural agency reported that during those long trips for gas or other needs, survivors often change their minds and take that opportunity to leave. In addition, in-home care workers who provide services such as housekeeping, personal care, attendant care, and respite for seniors and individuals with disabilities, are harder to find and require more pay per hour due to the distances between homes.

Many clients served don't have their own transportation. In rural Arizona, there is very limited transit or even bus services, as rural communities can't afford the high cost of providing transportation services. Using Pinal County as an example (5,374 square miles), there are two small human service transit systems. Without public transportation, it is difficult for individuals, such as seniors, to get much needed basic services, such as grocery shopping, medical appointments, or picking up medications. In Yavapai County, only Cottonwood has a local bus system. To further compound the issue, in Casa Grande, the Greyhound bus service recently ceased. The United Way of Pinal County provided bicycles as an option for survivors of domestic or sexual violence and homeless individuals to get to where they need to

be. Individuals have been known to ride these bikes on long stretches of poorly lit rural roads with no bicycle lanes, in the middle of the night to get to their jobs.

Housing

Housing is also critical for many low-income families and the challenges for housing are multifaceted. In many counties, such as Pinal, Cochise, Santa Cruz, and La Paz Counties, there is simply a lack of affordable housing. When affordable housing is available, single individuals with full time jobs, earning minimum wage, are overqualified for subsidized housing. Some housing programs have a limit on the number of children they allow. Larger homes to accommodate larger families are very difficult to find. As a result, it is harder for families with large numbers of children to find housing.

In some rural counties, there are housing locators, focused on finding landlords that will work with service providers to help people find homes. Over time, some of those landlords stop working with agencies because people who are homeless may not have a job or have a poor credit history and they would rather not rent to them. As a workaround, service providers negotiate with these same landlords with partial rent payments, with the caveat that the agency will work with renters to find jobs.

Felony convictions pose one of the greatest barriers to housing. Even if those felonies are not drug, violence, or weapons related, often times a felony record makes people ineligible for affordable housing. They feel they have nowhere to go. In addition, housing is becoming more and more expensive. In Pinal County many apartments that used to be under the Low-Income Housing Tax Credit are now charging market rates vs. subsidized rates and making housing that much more difficult to obtain. In Yavapai County, rents have exploded. For example, a two-bedroom apartment rent starts at $1,200 per month and many single parents can't afford rent plus childcare.

Sexual Assault

Survivors of sexual assault face a severe lack of sexual assault services and sexual assault nurse examiners (SANEs) to complete a forensic exam. In Gila, Cochise, Santa Cruz, Mohave, and La Paz Counties, there is no access to a SANE nurse. Arizona has no stand-alone rape crisis centers, and some counties lack sexual assault specific services entirely. Moreover, there are very few Sexual Assault Response Teams (SART) in Arizona's rural counties. Service providers are more often limited to informal collaborations with underdeveloped, if any, interagency protocols to help survivors of sexual assault.

Survivors need legal services as they navigate their circumstances, such as divorce, immigration, supervised visitation and safe exchange, custody, and orders of protection. In most rural counties, there is a severe shortage of affordable legal services. In 2018, Catholic Social Services lost their grant to provide free legal services for victims in Southern Arizona. Their only options may be the rare volunteer attorney or lay legal advocates, who can help, but who are restricted from performing even simple legal services such as completing forms.

Behavioral Health

There is an increase in the need for services for individuals with behavioral health, serious mental illness (SMI) or substance abuse issues. According to the ADHS Individuals with a Serious Mental Illness Annual Report (2015), the majority (52 percent) of members with SMI reside outside of Maricopa County. They

are predominantly female (55.5 percent) and only 13.4 percent are employed. These are extremely difficult to address in rural Arizona. For example, in La Paz, Gila, and Cochise counties, intensive counseling or substance abuse services are severely limited or unavailable. Globe has lost their regional behavioral health authority (SEABHS). For those needing residential behavioral health or substance use treatment, services are available in Phoenix or Tucson -- a 3- or 4-hour one-way trip. In Yavapai County, the only substance abuse center is in Prescott. The center doesn't accept children, so parents with children are not able to get the treatment they need. Anecdotally, as a demographic group, individuals with SMI experience high rates of domestic and/or sexual violence. That reality is illustrated by the number of increasing number of individuals with SMI in domestic and sexual violence crisis shelters. Unfortunately, although staff do everything they can to wrap services and supports around families, services are scarce, and staff (outside of the behavioral health arena) are not trained or equipped to address exceedingly emergent behavioral health or substance abuse needs.

Immigrants

Immigrants have additional barriers that place them in situations where they are forced to make decisions that are not conducive to their well being or safety. Rural agency directors report that the increased presence of border patrol officers in their areas frequently keep families from seeking assistance. In Cochise and Santa Cruz counties, four border checkpoints constrict access to services, as families who are fearful of deportation and/or family separation choose not to cross those checkpoints into Tucson. When immigrants can connect to services and supports, it is challenging for organizations to provide culturally responsive services due to the difficulty in finding staff who are bilingual and bicultural.

Rural cities and towns are experiencing lower revenues from varied funding sources or big business. They have historically depended on tax revenue and contributions from industries, such as mining. Mining, however, is presently experiencing a reduction in production and jobs. As a result, nearby cities and towns are forced to prioritize available funds for basic needs, such as water, roads, police, and fire, placing family services and supports lower on the priority for available funding. That budgetary realignment then results in fewer jobs and a reduction of family support systems, such as for seniors, individuals with disabilities and working parents. They are negatively impacted because family members leave their rural homes for urban areas where there are better employment opportunities and pay.

Funds from foundations and philanthropic endeavors are not usually available or focused on rural communities. Those that are, such as the United Way of Pinal County, have changed their focus and no longer provide funding for some things, such as for meal programs and employment related expenses (such as vehicle insurance and repairs, uniforms, etc.) as they once did.

Population

In Pinal and Yavapai counties, the senior population (60-years and older) has doubled in the last 20 years. One agency director characterized the problem as a "growing tidal wave of an elderly population with less resources." A reality is that funding from federal and state government for meal programs and support for in-home care services has not increased commensurate with the increase in demand, leaving agencies little to work with. In addition, due to geographic isolation, it is harder to get the word out to seniors about fraudulent schemes and scams, making our frail and vulnerable elders more at risk for exploitation and neglect.

Service Providers

Service provider agencies are met with the challenge of recruiting, training and retaining staff that have the experience, education and qualifications needed. For many agencies, it can take as long as three months to fill an open position. Even when staff is available, retention is a challenge, as rural organizations lose staff to urban areas where there are significantly higher paying jobs. In the medical and behavioral health arena, psychiatrists, nurses and licensed counselors are very limited and very difficult to hire. A few organizations in rural Arizona have begun to implement teleconferencing to increase access to practitioners otherwise not available in their area. However, technology and information infrastructure are not always available.

As services and supports are assessed on a statewide basis, it is critical that the rural factor be extrapolated and considered. Funding should include rural modifiers to account for additional costs associated with characteristics of rurality, such as poverty, distance, resources, services and supports, inadequate workforce, and transportation needs. Service providers will need to continue developing innovative solutions as well as collaborations and partnerships to ensure families and survivors of domestic and sexual violence receive the services and support they need. When collaborations and partnerships are not enough, service providers may need to consider increased use of teleconferencing to mitigate a lack of service professionals in rural Arizona.

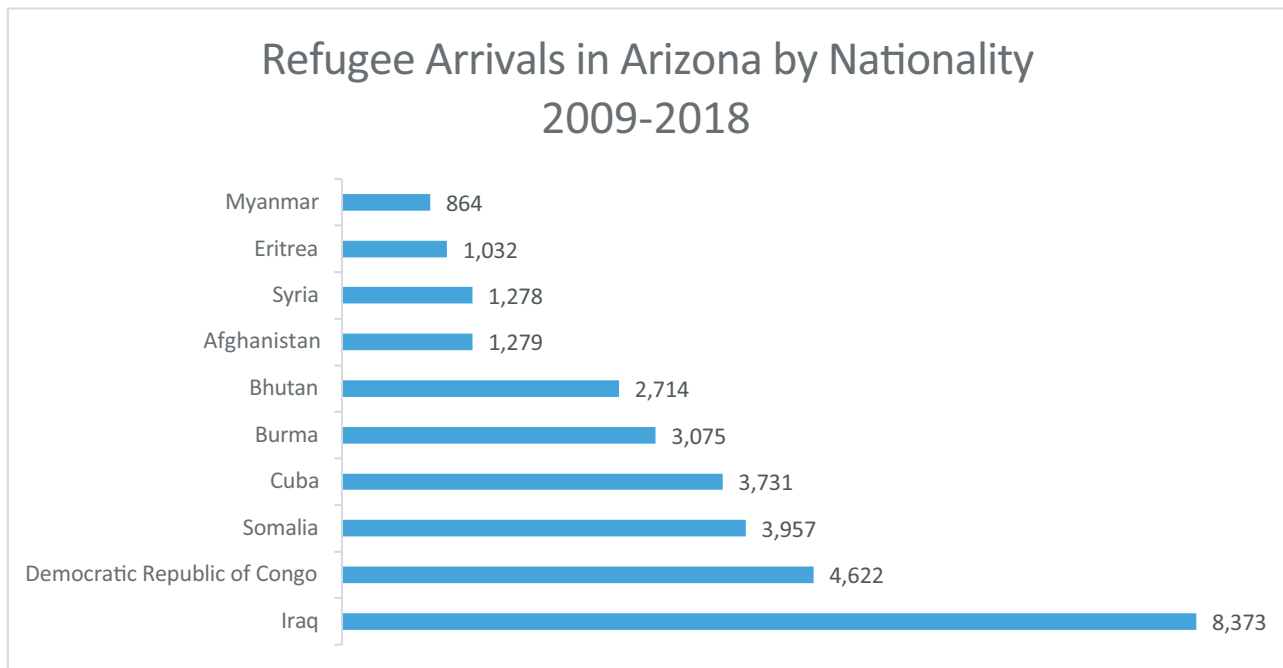# SPOTLIGHT ON ADDRESSING REFUGEE FAMILY NEEDS

By David Schlinkert
Policy Analyst, Morrison Institute for Public Policy

Access, Understanding and Institutional Responses

Refugees face similar familial, domestic violence and abuse challenges as Arizona's general public. However, they face additional hurdles in accessing services and integrating into their communities because of language barriers, cultural norms and Arizona's institutional responses.

Refugees are defined as people who are persecuted in their home countries because of their race, religion, nationality, political opinion, or membership in a particular social group.[1] They often flee under duress, immediate risk or emergency – due to violence and war. All refugees that come to the United

Figure 1.

Refugee Arrivals in Arizona by Nationality
2009-2018

Nationality	Arrivals
Myanmar	864
Eritrea	1,032
Syria	1,278
Afghanistan	1,279
Bhutan	2,714
Burma	3,075
Cuba	3,731
Somalia	3,957
Democratic Republic of Congo	4,622
Iraq	8,373

Data Source: *Department of Economic Security's Arizona Refugee Resettlement Program[2]*

[1] United Nations General Assembly. (1951). Convention Relating to the Status of Refugees. Retrieved October 20, 2018 from: http://www.refworld.org/docid/3be01b964.html
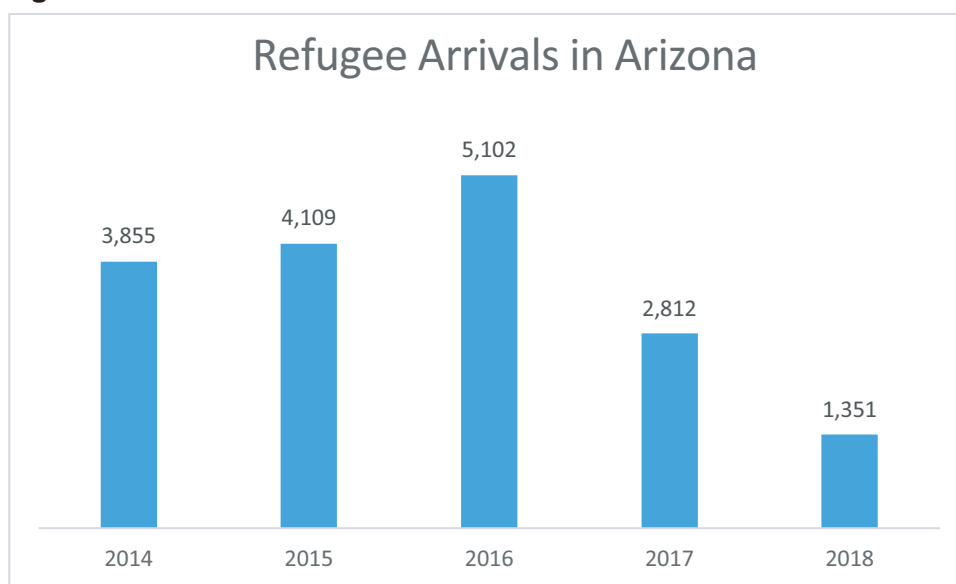[2] Department of Economic Security. (2019). Arizona Refugee Resettlement Program. Retrieved from: https://des.az.gov/sites/default/files/Refugee_Arrivals_Report.pdf

States go through the U.S. Department of State's comprehensive legal and medical vetting process before resettlement.[3] All refugees in the U.S. are here legally and are eligible for a Green Card (permanent resident card) one year after their presence in the country, and they can apply for citizenship five years after arrival.

Since 1981, Arizona has resettled 82,982 refugees from 102 different countries.[4] Figure 1 shows the top ten most resettled nationalities in Arizona over the last ten years.

Due to federal changes in the number of refugees allowed to enter the country,[5] and a travel ban,[6] there was a decrease in the number of refugee arrivals in 2017 and 2018. Overall, refugee arrivals in Arizona have decreased by 65% since 2014 (Figure 2).

Figure 2.

Refugee Arrivals in Arizona

2014	2015	2016	2017	2018
3,855	4,109	5,102	2,812	1,351

Data Source: *Department of Economic Security's Arizona Refugee Resettlement Program[7]*

Access and Understanding

When refugees arrive in the U.S., they have access to rapid-employment and case management services for 90 days after arrival. Many refugees can receive case management and employment services for up to five years through the agency that resettled them. There are nine resettlement agencies in the U.S.; four of them operate in Arizona.

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[3] U.S. Department of State. (2019). U.S. Refugee Admissions Program. Application and Case Processing. Retrieved March 13, 2019 from: https://www.state.gov/j/prm/ra/admissions/
[4] Refugee Arrivals by Nationality and FFY of Resettlement. (2019). Arizona Refugee Resettlement Program. Retrieved March 18, 2019 from: https://des.az.gov/sites/default/files/Refugee_Arrivals_Report.pdf
[5] Presidential Determination on Refugee Admissions for Fiscal Year 2018. (2017). Federal Register. National Archives. Retrieved March 18, 2019 from: https://www.federalregister.gov/documents/2017/10/23/2017-23140/presidential-determination-on-refugee-admissions-for-fiscal-year-2018
[6] Gladstone, R., Sugiyama, S. (2018). Trump's Travel Ban: How It Works and Who Is Affected. The New York Times. Retrieved March 18, 2019 from: https://www.nytimes.com/2018/07/01/world/americas/travel-ban-trump-how-it-works.html
[7] Department of Economic Security. (2019). Arizona Refugee Resettlement Program. Retrieved from: https://des.az.gov/sites/default/files/Refugee_Arrivals_Report.pdf

Some refugees come to the U.S. with limited English proficiency, low educational attainment, and a lack of formal and documented work experience. This may exacerbate health, housing, education and integration challenges. However, according to an Urban Institute study, despite these challenges, refugees' economic contributions outweigh their costs after several years in the country, and their children's high school graduation rates are similar to their U.S. born peers.[8]

Language Access During Domestic Violence and Abuse

Despite educational and economic successes, refugees still struggle to find adequate language interpretation in Arizona, especially when they are experiencing a family emergency or speak a unique language or dialect that lacks trained interpreters. Healthcare, safety and public service providers in Arizona require additional training and support to understand the cultural and political contexts refugees come from in order to provide culturally relevant services, and secure the assistance of trained language interpreters when needed.

If refugee families enter into the Department of Child Safety (DCS) or a Domestic Violence (DV) shelter, they can face additional language and cultural understanding and competency barriers. Staff at DV homelessness shelters may not be aware that many countries where refugees come from do not have specific laws against domestic violence, sexual harassment or marital rape.[9]

> **A Refugee's Experience with Domestic Violence in Arizona**
>
> In 2014, a refugee mother was assaulted by her husband in Maricopa County. When she tried to add her children to her order of protection, the court delayed her case twice because it was unable to find an interpreter that spoke her dialect. This lack of proper interpretation, coupled with her community's desire for her to return to her husband, contributed to ongoing abuse.

According to research from Arizona State University Assistant Professor Karin Wachter, multiple factors limit refugee women's access to supportive services including gaps in information, silence and stigma surrounding violence against women, economic concerns, family and community dynamics, and communication challenges.[10] Refugee DV survivors in the U.S. will often need additional education about their legal rights, the U.S. legal system, housing, and job supports so they can remain physically and financially safe.

When a refugee family becomes involved with the DCS system, and children are removed from the home, it can be incredibly challenging for them to get their children back. DCS court cases may require that parents attend treatment, support groups, and other services that are oftentimes not available in the client's native language, or are not available in a culturally relevant form. This makes it difficult for refugee families to follow DCS guidelines, learn from their mistakes and overcome their previous cultural norms to reunify with their children. This increases the number of children in Arizona's DCS and foster care systems.

[8] Bernstein, H., DuBois, N. (2018). Bringing Evidence to the Refugee Integration Debate. Urban Institute. Retrieved March 18, 2019 from: https://www.urban.org/sites/default/files/publication/97771/2018_05_15_bringing_evidence_to_the_refugee_integration_debate_finalized.pdf

[9] The World Bank. (2017). Gender Equality. Achieve gender equality and empower all women and girls. The World Bank. Retrieved from: http://datatopics.worldbank.org/sdgatlas/archive/2017/SDG-05-gender-equality.html

[10] Wachter, K. & Dalpe, J. (2018). *Bridging the Gaps: Addressing Refugee and Immigrant Women's Experiences with Domestic Violence and Sexual Assault*. New York, NY: International Rescue Committee.

English Proficiency and Knowledge of U.S. Systems

Command of the English language also plays a significant role in refugee household power dynamics. Arizona's refugee resettlement agencies do an excellent job of enrolling refugee children in school. The challenge for refugee children, then, is not enrolling in school, it is adapting to their new role as a language interpreter for their parents. Despite challenges with English-only immersion programs in schools, the advantage for refugee children is that they learn English before their parents – primarily because refugee parents begin working within their first 90 days in the country and may not receive adequate language instruction. This puts children in the position where they become cultural brokers, capable of communicating with the outside world for their parents. This can create tensions in the home, as parents feel that they lose control over their children. The children's newfound knowledge of English can also lead to medical and legal providers inappropriately using children as interpreters for their parents during complicated and confidential affairs because providers do not know of, or refuse to contact, proper interpretation services, which are required by law.[11]

Another major barrier to refugees accessing services can be their lack of understanding of the U.S. government, institutions and civil society. Oftentimes refugees are afraid of government authorities in the U.S. due to their experiences with authoritarian governments in their home countries. Many refugees may also lack the self-advocacy skills needed to work through complex government agencies and bureaucracies to access the services they need to get started in the U.S.

Institutional Responses

Many of Arizona's employers, government agencies, universities, nonprofits, churches, health clinics, and immigration and advocacy groups work with refugees. Because refugees come from a diverse array of countries, it is difficult to train all of these groups on how to best work with each refugee nationality group.

One successful area, however, can be large-scale targeted changes to policies and eligibility requirements. For example, one challenge for refugee families in Arizona is access to services from Arizona's Division of Developmental Disabilities (DDD).[12] When an individual with a developmental disability qualifies for DDD services, they can receive case management services along with a plethora of additional supports.[13] To qualify for these DDD services, an individual must have proof that their developmental disability began before they turned 18. Some refugees arrive in the U.S. with a disability that would qualify them for DDD services, but because they did not receive the proper medical documentation before they turned 18 (oftentimes, proper medical care is nonexistent in their home countries), they will live the rest of their lives without the same services afforded to individuals born in the U.S. And, according to the Centers for Disease Control and Prevention, "children with disabilities may be at a higher risk for abuse or neglect than children without disabilities."[14] This may make these refugee families more susceptible to abuse.

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[11] Chen, A., Youdelman, M., Brooks, J. (2007). The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond. US National Library of Medicine. National Institutes of Health. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609/

[12] The Division of Developmental Disabilities is a division within Arizona's Department of Economic Security.

[13] Arizona Department of Economic Security. (2019). Available DDD Services & Supports. Division of Developmental Disabilities. Retrieved March 18, 2019 from: https://des.az.gov/services/disabilities/developmental-disabilities/individuals-and-families/supports-and-services

[14] Centers for Disease Control. (2019). Safety and Children with Disabilities. Childhood Maltreatment among Children with Disabilities. Retrieved March 19, 2019 from: https://www.cdc.gov/ncbddd/disabilityandsafety/abuse.html

Another promising response to refugee family needs is empowerment programs. Since 2012, ASU professors Dr. David Androff and Dr. Barbara Klimek have partnered with nine grassroots refugee community-based organizations comprising newly arrived refugees from Burma, Bhutan, Congo, Iraq, and Somalia to provide education about community integration in a culturally sensitive manner. This ASU Refugee Empowerment Project built the capacity of refugee organizations to deliver their own cultural orientations, increasing the knowledge level of newly arrived refugees attending the orientations, and fostering social entrepreneurship among refugees. The project contributed to a social transformation among refugees, exemplified by the creation of the New American Community, Inc., the first intra-refugee cooperative in Arizona.

Refugees are resilient, capable and motivated individuals.[15] And with welcoming communities and supportive policies and institutional responses they can get access to quality resources, education and jobs, which will enable them to build stable and unified families that can prosper in Arizona.

[15] Hutchinson, M., Dorsett, P. (2012). What does the literature say about resilience in refugee people? Implications for practice. Journal of Social Inclusion. Retrieved April 3, 2019 from: https://josi.journals.griffith.edu.au/index.php/inclusion/issue/view/34

GOVERNMENT SYSTEMS AND CAPACITY

By Janet Garcia
Arizona Senior Director, Casey Family Programs
and Kristin Borns
Independent Consultant, Borns Solutions AZ

System Integration: From a Child Welfare Perspective

Families are complicated, each in their own unique way. The challenges of raising children, working, keeping a roof overhead and simply keeping the wheels moving day-to-day can be a struggle for many. When a family reaches a crisis point and the Department of Child Safety (DCS) - Arizona's child welfare agency - becomes involved, the stressors of the situation, coupled with the labyrinth of often stand-alone programs, can seem nearly too complex to navigate.

Integration of services and supports needed by a family in the DCS system is a complicated, difficult goal. If it were simple, the silos would have been torn down in any of the previous incarnations of the child welfare system.

However, there are examples throughout the community of small-scale collaboration and integration that are making a difference for families. Understanding current system challenges, as well as localized successes, can provide a pathway to a more meaningful and widespread integration of services for families in the DCS system (see text box 'Why focus on families with DCS?' for population focus of chapter).

> **Why focus on families involved with DCS?**
>
> The universe of families experiencing crisis and vulnerability is vast. Families can experience financial emergencies, housing loss, health and wellness crises or hunger. Families engaged with the Arizona Department of Child Safety are uniquely positioned to often experience a mix of these issues concurrently. In order to provide situational expertise and specific examples of integration difficulties and successes, this chapter will focus specifically on DCS families and the variety of systems they interface with in working towards safety and stability.

A Brief Snapshot of Vulnerability

Families engaged with the DCS system rarely are dealing with one issue or addressing a single challenge. Substance abuse, domestic violence and mental health issues are often present and DCS must work with the family to tackle all simultaneously.

Underlying many of these issues for families involved with DCS is also poverty. "The well-being of children is tied generally to poverty because families without material resources often struggle to raise children without assistance."[1] As a result, many families in the DCS system are working to access cash benefits (TANF), food stamps (SNAP), Subsidized Child Care, Safe Housing and other basic need services.

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[1] Chapin Hall at the University of Chicago (2015, June 26). *Arizona Department of Child Safety Independent Review.*

These programs are administered by the state's Department of Economic Security (DES). However, currently there is no direct connection between the state's child welfare department and the designated DES divisions. As a result, families applying for TANF and SNAP must provide a large amount of information: the downloadable paper application is 50 pages in length. While this application can be completed online and allows a family to simultaneously apply for TANF, SNAP and medical assistance (Medicaid), it is cumbersome, extensive and requires a large time commitment.

In addition to the application questions, families must provide a variety of required documents including, but not limited to: proof of citizenship, social security numbers for everyone in the home and proof of relationships in the home.

Once this is complete, individuals are still required to schedule an in-person or phone interview. Finding time to do this requires time away from work - likely from jobs that do not provide paid time off - and can be yet another burden.

This large application also allows a family to apply for medical assistance. Until very recently, the application would have only covered benefits for physical health. However behavioral health services have recently (October 1, 2018) been integrated with physical health services, allowing a family to apply for both kinds of coverage with one form. It is too soon to tell if this example of service integration is providing the easier access intended.

Finally, for these three critical support services, with exceptions for emergency need, families can wait up to 30-45 days for a determination.

Sample Services for Vulnerable and At-Risk Families

Service	Agency Responsible
Child Safety	Department of Child Safety
Cash Benefits	Department of Economic Security – Division of Benefits & Medical Eligibility
Food Stamps	Department of Economic Security – Division of Benefits & Medical Eligibility
Social Security Administration Disability	Department of Economic Security – Division of Benefits & Medical Eligibility
Child Care Subsidies	Department of Economic Security – Child Care Administration
Medical Benefits – Physical & Mental Health	Department of Economic Security – Division of Benefits & Medical Eligibility (*Application*) Arizona Health Care Cost Containment System – Division (*Application & Administration. Program dependent upon who is covered*)
Developmental Disabilities	Department of Economic Security – Division of Developmental Disabilities
Women, Infants, and Children Food and Nutrition Service	Department of Health Services – Division of Nutrition & Physical Activity

This example demonstrates the time commitment and barriers a family can experience accessing just one system - the system serving the most basic of needs. It also illustrates how important effective system integration is in supporting the success of a family involved with DCS. Efforts are being made to prioritize access to services for families involved with DCS. While this is a worthy effort, it does not address the need for services to prevent the need for DCS intervention.

Frontline Voices

Families in the DCS system don't just interact with their DCS case manager. They are required to engage with a variety of services, designed to provide support and treatment as necessary. As a result, community providers are the frontline of service for families involved with DCS. They most often carry

the burden of working within a system that is not integrated or at times even coordinated. It is these community providers who have a front-row seat to the challenges faced when a family is trying to address multiple issues and when children and their caregivers need multiple services.

In the following section, these providers share their insights into where some of the most pressing current challenges are within the system; where there are bright spots and localized integration; and finally, where Arizona can leverage opportunities to integrate services for families in the child welfare system.[2] This list is not intended to be exhaustive but it does provide real-world insights that can be used as a springboard to systemic improvements.

System Challenges: Families Out of the Driver's Seat

Providers who shared their experience with the DCS system and service integration often saw challenges as opportunities and opportunities fraught with challenges. However, each articulated that there were clear barriers to integration that were impacting children and caregivers in the DCS system.

An overarching theme is the value of prevention services and the devastating impact the loss of many of those services has had on families. Fully funded, wisely administered and easily accessible prevention services can keep families out of the child welfare system. The erosion of financial support, and the prevention services that support funded, was a key challenge identified by the provider group.

Unpredictable and diminished funding for family support services was another foundational challenge noted. Discussion participants pointed to a state revenue base that has slowly been chipped away over many years by tax reductions. As a result, when the Great Recession struck and state revenue plummeted, Arizona saw unprecedented numbers of children in out-of-home care.

The way funding, much like services, is siloed also creates barriers. When dollars are narrowly designated and how they must be used is limited, community providers often take a competitive rather than collaborative stance with one another. This creates an environment in which the community cohesion needed for integration has difficulty taking root.

DCS staff turnover also came up frequently as a challenge to effective service and systems integration. Caseworkers often receive low-pay for working in an extremely high-stress, high-visibility profession. This creates a workforce that is in churn and often largely unaware of what services exist and how to access them.

The need for culturally sensitive and culturally specific services was also highlighted as critical to ensuring successful outcomes.

Additionally, regardless of the specific support or system, providers highlighted that how, when, where and by whom services are delivered is dictated by the system, not by the family or child. A further layer of challenge exists in that each of these individual programs often has a designated case manager responsible for driving their unique approach or treatment. This can result in overlapping or conflicting

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[2] The following is a summary based on a discussion with individuals engaged directly with the DCS system. Participants: Janet Garcia, Casey Family Programs, Facilitator; Pete Hershberger; Doreen Nicholas, Arizona Coalition to End Sexual and Domestic Violence; Ken McKinley, United Methodist Outreach Ministries (UMOM); Jakki Kolzow, Casey Family Programs.

guidance for families leading to confusion and potential burnout. An integrated system allows for individualization and flexibility, with families being the center of a holistic process where partners come together and provide the services the family needs, rather than selecting from a pre-determined list of available services.

Just as concerning for providers was how services and delivery are often shaped by arbitrary requirements. For example, there is an expectation that the day a youth turns 18 s/he is suddenly ready to exit the DCS system. Developmental milestones, not years, should drive services. Fortunately, there is movement away from this mindset, but there are still a multitude of programs that are driven by arbitrary and unmovable guidelines.

Additionally, youth aging out of the DCS system specifically are challenged by a lack of focus on helping youth establish "permanency" in support and social networks when they leave the DCS system. Research shows that youth who age out (turn 18 without obtaining legal permanency through reunification, adoption or guardianship) are much more likely to experience negative outcomes including incarceration, homelessness, teen births. However, current incentives and programs can encourage older youth to age out. For example, youth must age out of the system to be eligible for a living stipend or state funded health insurance.

Providers also shared that policymakers and programs don't utilize research that demonstrates the value of integrated services and coordinated systems. Best practices research should play a part in guiding family case plans. FosterEd, a program shown to improve educational outcomes for youth in foster care, leveraged valid research to expand its program by highlighting the documented achievement gap for those in foster care. Overall, however, participants feel like there are not enough examples of research-driven policy.

A lack of understanding and integration of research and best practice with families experiencing domestic violence was discussed. Specifically, providers find that when there is domestic violence occurring in a family, the DCS case plan often focuses on only engaging the victim parent and placing a variety of requirements on that parent. Requirements such as securing affordable housing and establishing safe childcare are often difficult to meet and can feel like a "full-time job" for the victim parent. This process often misses the criticality of also including the perpetrator parent in the case plan.

Those youth identified as the hardest to serve were also discussed as a key system challenge. Often providers simply view their aging out of the system as the best approach when in reality they are the most in need of targeted, integrated services.

While meeting the physical and dental health needs of families involved with DCS can be difficult, access to behavioral health care was the most dominant issue raised by providers. Providers said that while the recent integration of behavioral health services with physical health services through Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, could bring about better coordination, there is not a lot of optimism in the community. While there may be benefits from removing layers of administration for those in need of services, providers felt that the driver behind the change was financial savings, not true system integration.

Finally, providers said that access to childcare is a key challenge for families involved with DCS. Lack of access to affordable childcare is often a contributing factor to families coming to the attention of DCS. Once children are taken into care, the caregivers qualify for a child care subsidy administered by the

Department of Economic Security. However, the subsidy often does not cover the full cost of childcare. Additionally, once a parent successfully completes their case plan, the subsidy for the child(ren) comes to an end. At that time, the parent will need to re-apply for a subsidy and prove financial eligibility. This requires the completion of an eight-page application along with the provision of information on employment or income from other sources. For teen parents, proof of school attendance is also needed. The parent then waits up to 30 days for their application to process. This process is cumbersome and could result in the family experiencing instability while waiting to receive approval.

Bright Spots: Small-Scale Coordination

While system integration is a long-reaching and difficult goal, there are a variety of localized examples where providers are coordinating for the benefit of families involved with DCS. One notable success is the overall reduction in Arizona children in out-of-home care. While providers agree more can be done, there is recognition of the state's improvement.

Providers also recognized that throughout the system there is an emerging recognition of the impact of trauma and the need to utilize trauma-informed care with families involved with DCS. Practice still lags behind understanding, but the provider community's recognition of trauma's impact was an improvement identified by all discussion participants. Community awareness of the reality and impact of human trafficking was another example of increased knowledge and understanding cited by the group.

While there is still a long-standing expectation that youth are ready to transition out of the DCS system at 18, there is growing recognition that 18 doesn't automatically confer readiness. Youth who do age out may voluntarily continue DCS services including case management, independent living stipend and financial assistance for college if they meet certain criteria. Unfortunately, the majority of youth do not opt in for ongoing services and, when they do, are often unable to comply with the requirements to remain eligible. More emphasis is being placed on legal and relational permanency for older youth so that the ongoing support of caring adults is present to assist youth in navigating the challenges of young adulthood.

Other changes that have served to improve service delivery to DCS youth and families include a move away from a law enforcement approach in crisis situations to a more therapeutic response. There is also a recognition that DCS children need a sense of "normalcy" in addition to safety. This includes allowing social opportunities their non-DCS peers access and providing the chance to experience traditional milestones, such as receiving a first cell phone or learning how to drive.

Finally, providers shared that beyond the traditional system players such as government and community agencies, the engagement and commitment of Arizona's philanthropic community is a positive that should not be overlooked.

Providers did share several specific efforts they saw as community "bright spots" that could provide lessons learned for more large-scale integration.

Cradle to Crayons: A Maricopa County program, Cradle to Crayons is led by the courts and brings together therapeutic providers, DCS, service coordinators and other professionals to work collaboratively to expedite reunification or other permanency options for children birth to three.

KARE Family Center: A program jointly administered by Casey Family Programs and Arizona Children's Association in Tucson, the KARE (Kinship and Adoption Resource and Education) Family Center is a known community resource for kinship caregiver support and families in the DCS system. Services for families include assistance in system navigation and support groups along with case management.

FosterEd: Beginning as a pilot in Pima County and leveraging research demonstrating the achievement crisis for foster youth, FosterEd recognizes that successful education outcomes for foster youth are key to their long-term success and well-being. Driven by a mission that foster youth graduate high school with an array of future possibilities, FosterEd seeks to work with education systems not used to working with foster children through on-site professionals, coordinated teams and student-centered engagement.

First Things First: First Things First funds programs serving children birth to five years in areas including quality childcare, health and family support. Applying a localized approach, First Things First uses community-led councils in regions across the state to identify needs and fund corresponding services.[3]

Arizona Families F.I.R.S.T.: A program established through a partnership between state agencies, Families F.I.R.S.T. "helps parents address substance abuse issues that are affecting their ability to care appropriately for their children or to get and keep a job. It provides the opportunity for families to overcome the barrier of substance abuse in order to reach the outcomes of permanency for children, family reunification and self-sufficiency." Providers work in collaboration with DCS and the family to provide substance abuse treatment as part of the DCS case plan.

Arizona Faith Community: Providers shared that the faith community works in a collaborative way to help fill gaps where more formal services are not available. Specifically, the Open Table and Care Portal programs were highlighted. Open Table engages community in providing a "wrap-around" support system for youth who have aged out of the DCS system. The Care Portal has evolved from a system that only served foster families to one that is now also designed to fill the prevention gap. Started by the Governor's Office and in Maricopa and Pima counties, DCS case managers can use a computerized system to share family need and the system then identifies churches local to the family who fill that need. The Care Portal is designed to not just provide the requested items, but for that provision to hopefully keep the family from entering the DCS system.

Collective Impact for Child Safety and Well-being: A community-driven collaborative supported by multiple philanthropic entities and community stakeholders, the Collective Impact effort brings together community leaders from across the continuum of care for children in the child welfare system with philanthropy, business and other stakeholders. The group is focused on creating a common agenda that will guide multi-agency, multi-sector approaches to working with families who come into contact with DCS. The focus of the effort is prevention of removal or re-removal of children from their family.

Direct Provider Relationships: The impact of provider-to-provider connections was highlighted in the collaboration between UMOM New Day Centers and Phoenix Children's Hospital. When youth come into the UMOM program, within 24-hours Phoenix Children's Hospital is at the program site providing a physical health assessment.

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[3] Created by Arizonans, First Things First partners with families and communities to help Arizona's youngest children be ready for success in kindergarten and beyond. With statewide oversight and accountability, decisions about how to invest early childhood funds are made at the local level by community leaders serving on regional councils who rely on data and invest in proven programs that address the development, education and health needs of children from birth to age 5.

Other potential pilot efforts occurring at the direction of the Governor's Office include integration of developmental disabilities services with acute and behavioral health for families; and a potential supportive housing program for mothers with substance-exposed newborns that will allow mothers to receive treatment while staying with their babies.

Opportunities

Building on community strengths, providers identified a number of opportunities to establish connections between programs with a goal of better system integration.

Comprehensive integration that addresses and centers family needs, encourages provider cooperation and creates community collaboration needs participation from multiple levels within a system.

Policymakers can craft policy that is research and best-practices driven, provides incentives for collaboration and coordinated case management and does not create arbitrary requirements.

Funders can allocate funding in a way that encourages community collaboration while meeting program needs. It is important to also provide adequate supports for those on the frontlines providing the service, including competitive pay.

Community agencies who are providing services can keep family needs at the center and build and strengthen relationships with other providers in a way that is collaborative.

Families can buy-in to the process and be able to access services that meet their individual needs.

Continuing to advocate and fund prevention services is a key opportunity for better service provision and reduction of the number of children in out-of-home care. The federal Family First Prevention Services Act will allow for more flexibility in funding and coordinating services. By focusing on preventing families from entering the child welfare system, the Act will allow for states to seek reimbursement for mental health, substance abuse treatment and in-home parenting supports for families at imminent risk of child removal to the foster care system. Services are available to birth families, kinship caregivers and adoptive families. Family First also includes financial incentives to keep children in family settings whenever possible, utilizing high quality congregate care settings only when it is therapeutically necessary based on an independent assessment.

Building on the recognition of trauma's impact, there is an opportunity to take that understanding and use it to increase trauma-informed services and trauma-informed practice. Continuing to use research on best practices to guide both integration and service provision is another opportunity.

Leveraging existing examples of small-scale integration can also provide an opportunity to scale these systems. For example, Arizona Families F.I.R.S.T. provides an integrative model for substance abuse treatment that could be applied to other service needs. The Safe & Together framework for working with families experiencing domestic violence could be another opportunity for more integrated service provision. Finally, FosterEd provides a roadmap for integrating foster youths' educational needs with other services.

The Child Family Team (CFT) model of decision-making and service provision within behavioral health could also be a focus point for further integration. As an existing care team, this model could expand the circle of family members and providers to facilitate integrated service to families involved with DCS.

Continuing to build on the strength of the faith and philanthropic communities could also be an opportunity for increased community engagement and integration.

Ultimately, elevating the family voice in service provision is critical to success. DCS is working to reinvigorate parent advisory committees, which will create an opportunity for insight from the most important participants in the process - the families.

Families Back in the Driver's Seat

Ultimately, service integration is a difficult, long-term and important goal. To move forward in creating positive outcomes for families involved with DCS, service integration will require stakeholders to:

Tackle long-standing competition between providers for funding and clients and reframe relationships as cohesive and connected.

Recognize community strengths while not shying away from existing challenges to identify and leverage opportunities for integration and collaboration.

Work with all system levels, from policymakers to funders to those served, to ensure integration is firmly entrenched top to bottom.

Re-orient and re-design services to place the family in the driver's seat and allow the services to follow the family, not the other way around.

INCREASING FAMILY CAPACITY: PROGRAMS AND SERVICES

By Claire M. Louge, M.Ed.
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Child Care Access and Affordability

In order to both maintain financial stability and promote optimal development of their children, Arizona families need access to high-quality, affordable child care. Sixty-one percent of Arizona children live in a household where all available parents are working, meaning that if the child lives in a single-parent household, that parent is working, and if the child lives in a two-parent household, both parents are working.[1] High-quality child care not only serves as a safe place for children to go when their parents are working, it also provides an educational setting where children can build the foundation for a lifetime of learning.

Ninety percent of a child's brain architecture develops before the age of five, meaning that the vast majority of foundational brain development occurs before a child's first day of kindergarten. Child care settings present an opportunity to promote optimal brain development during one of the most critical and influential periods of a child's life.

In early education, quality matters. High-quality early education programs go beyond basic health and safety and include the following elements:

- Teachers/caregivers who are educated on child development and know how to work with young children
- Environments that nurture language, pre-literacy skills, social and emotional competence, and cognitive development of every child
- Positive, predictable, nurturing relationships between teachers and children
- Hands-on learning activities that promote brain connections in children
- Strong communication between teachers and parents.

Child care settings can also create opportunities to build protective factors. Child care providers usually have frequent, brief interactions with parents during drop-off or pick up times, these moments can be used to gauge a parent's need for support or to connect parents to resources. Parents can meet the parents of other children at the center, facilitating social connections. Some child care programs host parenting education classes or other events, promoting knowledge of parenting. Early educators often serve as models or coaches of parenting strategies. Child care centers usually have a resource area where parents can pick up resource information or parent education materials based on their family's needs.

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[1] Center for the Study of Child Care Employment. (2018). *Early Childhood Workforce Index 2018 - Arizona*. University of California, Berkeley. Retrieved from: cscce.berkeley.edu/files/2018/06/2018-Index-Arizona.pdf

Not only do high-quality child care centers care for children, they strengthen the whole family.[2]

High-quality care, however, costs more and most Arizona families cannot afford the cost of high-quality child care. In order to best support more families and children, affordability of child care is an important component of the issue.[3]

Program Example: Quality First

Quality First is a signature program of First Things First,[4] the voter-created Arizona state agency dedicated to the health and school readiness of young children age five and under. Through coaching, assessment, and resources, Quality First works with regulated early childhood providers in Arizona to build the quality of their child care center or preschool to promote learning and development. The program also offers information to parents on what to look for when searching for child care, and the elements that promote the optimal development of their child.

Quality First also offers scholarships to assist some families afford the cost of child care. In 2017, 8,700 Arizona children were able to attend a high-quality early educational setting with the help of a Quality First Scholarship, allowing their parents to work or attend school.

Despite this large investment from First Things First, the need is greater than the available resources.[5]

Parenting Education

Parenting is partly intuitive and partly learned. Parenting education provides an opportunity for parents and caregivers to acquire knowledge, skills, and tools for their job as a parent. Parents acquire parenting knowledge and practices through a variety of means, including from family, friends, literature, media, and the internet. Parenting education classes ensure that knowledge is factual, applicable, and developmentally beneficial to children.

The core concept of all parenting education is the strong relationship between parent and child. As is the case with all helping and teaching professions, relationships are the vessel in which knowledge and support is delivered. Parenting education can focus on a wide variety of topics, including forming realistic expectations of children, guiding child development, promoting social and emotional skills, discipline, and addressing challenging behaviors. A fundamental component to many parent education models is the focus on engaging the primary caregiver with their children in developmentally appropriate activities that encourage bonding and early learning for the child. Many programs also focus on helping parents develop problem-solving skills and learn about child development.

Parenting education can be delivered through other services, such as within a doctor's appointment,

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[2] First Things First. (2018). *Quality Matters in Child Care and Preschool*. Retrieved 2018 from: https://www.firstthingsfirst.org/resources/quality-first/

[3] Center for the Study of Child Care Employment. (2018). *Early Childhood Workforce Index 2018 - Arizona*. University of California, Berkeley. Retrieved from: cscce.berkeley.edu/files/2018/06/2018-Index-Arizona.pdf

[4] Created by Arizonans, First Things First partners with families and communities to help Arizona's youngest children be ready for success in kindergarten and beyond. With statewide oversight and accountability, decisions about how to invest early childhood funds are made at the local level by community leaders serving on regional councils who rely on data and invest in proven programs that address the development, education and health needs of children from birth to age 5.

[5] *The Path to Success Begins at Birth: First Things First 2018 Annual Report*(Rep.). (2018). Retrieved 2018 from: https://www.firstthingsfirst.org/2018/10/annual-report-details-impact-of-arizonas-early-childhood-investments/

home visit or parent-teacher conference. Parenting education can also be delivered passively, by making literature available in waiting rooms or lobbies of service organizations. Parenting education is also delivered in the form of single seminars or series of classes, both in person or online. The added benefit of having parents attend in person is the opportunity to form social connections to other parents.[6]

Program Example: Triple P

The Triple P – Positive Parenting Program® is an evidence-based parenting and family support program focused on addressing and preventing behavioral and emotional problems in children and teenagers. Triple P has a tiered approach with various levels of service that are flexible based on the needs of the family. It can be delivered through one-time in-person or online parenting seminars, or more intensely through individual work with families. This tiered approach makes it ideal for scaling the intervention across service delivery sites in public and private agencies with the common language of positive parenting.

Triple P aims to normalize help-seeking behavior in parents, and equip parents with the "skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support."

Research shows that Triple P decreases parent stress, parent anxiety, parent depression, child behavior problems, and improves parenting competencies, family communication skills, and family relationships. At a community level, Triple P decreases rates of child maltreatment, decreases out-of-home placements, and decreases child injuries due to maltreatment.[7]

Currently in Arizona, Triple P services are offered in-home, in the clinic/hospital, within schools and faith-based organizations, shelters, prisons, and online. An outcome evaluation last year indicated that over 1,400 parents/caregivers received Triple P services across the state.

Home Visiting

Home visiting programs provide parenting education and support in the child's primary environment – the home. Through home visiting programs, professional parent support specialists make regular visits to homes and engage families in individualized parent education, resource referral, goal-setting and skill-building based on their needs, culture, and circumstances.

Home visitation programs work to build protective factors in families and reduce the likelihood of child abuse and neglect. Home visiting professionals strengthen parental resilience by working with parents to build their own coping and self-regulation skills. Home visitation provides a family with a trustworthy, knowledgeable social connection- the home visitor – and many of these programs also hold parent connection events for families to get together, learn, and socialize. Home visiting programs partner with parents to determine the parenting skills they would like to work on, and routinely provide information to families based on the age and developmental stage of the child or children. The home visitor also acts as an ambassador to other community resources, and refers parents to other services as needed.

Like all effective family support programs, home visiting focuses on strengthening the relationship between parents and children. Home visitors serve as models, coaches and mentors. Since early childhood lays the

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[6] National Alliance for Children's Trust & Prevention Funds. (2012). *Bringing the Protective Factors to Life in Your Work- A Resource for Action*.
[7] Triple P in a nutshell. (n.d.). Retrieved 2018 from: https://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell/

foundation for the rest of a child's life, most home visiting programs focus on families with children ages five and under. Making home visitation programs widely available for voluntary participation is one of the most effective ways to prevent child abuse and neglect.[8]

Examples of home visiting programs in Arizona include Arizona Health Start, Early Head Start, Healthy Families Arizona, Nurse-Family Partnership, Parents as Teachers, Family Spirit, High Risk Perinatal Program/Newborn Intensive Care Program, and SafeCare.[9]

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[8] Daro, D and Harding, K. (1999). *"Healthy Families America: Using Research to Enhance Practice. The Future of Children."* Home Visiting: Recent Program Evaluations. Volume 9(1), pp. 159-167, 177. Los Altos, CA: David and Lucille Foundation Packard Foundation.
[9] Strong Families AZ. (2018). Programs to Help Parents in Arizona. Retrieved 2018 from: https://strongfamiliesaz.com/programs/

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Program Example: Healthy Families

Healthy Families is a home visiting program designed to help families face challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence. To maximize the positive impact of services, families are enrolled before the child is three months of age, and receive visits weekly until the child is six months old. After that, visits are conducted with the frequency needed by each family until the child is five years old.

Healthy Families home visitors provide culturally-sensitive, relationship-based parenting education and mentorship designed to promote positive parent-child relationships and healthy attachment. Home visitors also conduct routine child developmental and maternal depression screenings, resource referral, and goal-setting in collaboration with the family.[10]

Evaluation results from more than 20 states, including 12 randomized control trials, show that Healthy Families effectively reduces the likelihood of child maltreatment; improves child health, parent-child interaction, children's school readiness, and family self-sufficiency.[11]

Healthy Families has been in existence in Arizona for more than 25 years, and made available through funding from the Arizona Department of Child Safety, the Arizona Department of Health Services, and First Things First.

In 2016, there were approximately 84,000 births in Arizona.[12] Every year, about 52 percent of these births are paid for by the Arizona Health Care Cost Containment System (AHCCCS), meaning that the family is low-income.[13] Forty-five percent of these births are to single parents.[14] Sixty-four percent of Arizona parents have a history of trauma in their own childhoods.[15] These risk factors (poverty, social isolation and history of trauma) are some of the strongest predictors of child abuse and neglect.[16] When considered together, approximately 40,000 Arizona families have risk factors that would qualify them to benefit from the Healthy Families program. In 2018, 4,330 Arizona families were served by Healthy Families.

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[10] The Healthy Families America Strategy. (2015). Retrieved 2018 from: https://www.healthyfamiliesamerica.org/the-hfa-strategy-1/

[11] The Research into Healthy Families America. (2015). Retrieved 2018 from: https://www.healthyfamiliesamerica.org/research-articles/

[12] Live births according to selected maternal, prenatal care and delivery characteristics, birth weight, plurality, child's sex, birth order, and birth complications, Arizona, 2006-2016. (2016). Retrieved December, 2018 from: https://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/1b2.pdf

[13] Births covered by AHCCCS, (Medicaid). (2016). Retrieved 2018 from https://datacenter.kidscount.org

[14] Live births according to selected maternal, prenatal care and delivery characteristics, birth weight, plurality, child's sex, birth order, and birth complications, Arizona, 2006-2016. (2016). Retrieved December, 2018 from: https://pub.azdhs.gov/health-stats/report/ahs/ahs2016/pdf/1b2.pdf

[15] ACEs in Arizona Adults. (2016). Retrieved from Phoenix Children's Hospital, Injury Prevention Center, Strong Families.

[16] Risk and Protective Factors for Child Abuse and Neglect. (Feb 2004). Child Welfare Information Gateway. Retrieved from: https://www.childwelfare.gov/pubPDFs/riskprotectivefactors.pdf

HEALTHY RELATIONSHIP EDUCATION

By Chris Panneton, M.Ed.
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How Intentional Conversations Benefit Our Children and Families

As the class was wrapping up, I looked over the faces of the high school students sitting in front of me, and thought to myself, "We have been talking about healthy relationships for a while, I wonder if this information is sinking in?" Upon asking them, one girl shouted out, "Heck ya. My ex-boyfriend texted me this weekend, wanting to get back together. I told him, 'No way, dude.' I realized that how he was treating me was not right." Another girl shared, "I thought it was normal…that's how I see my mom and dad act." It became clear to me that these young ladies were grasping the concept of healthy relationships.

Children are not innately born with the skills and expertise to successfully sustain healthy and satisfying relationships.[1] Open communication, mutual respect, trust, honesty, and self-responsibility are a few of the essential elements that must be intentionally taught to children. Children observe and experience the interaction, behaviors, and norms within the family unit, which can become hardwired in their brain and impact the social construct of their adult relationships. Whether their childhood experiences are based on love and compassion, codependency and passivity, or power and control, these cycles tend to continue into adulthood.

To break the cycle of violence and empower interdependence, the need for healthy relationship education is apparent today more than ever. According to the Center for Disease Control, "Nearly 1.5 million high school students nationwide experience physical abuse from a dating partner in a single year."[2] "Girls and young women ages 18 to 24 historically experience the highest rate of intimate partner violence."[3] Healthy relationship education investments in our youth through programs that teach about recognizing types of abuse, understanding the cycle of violence and why people stay, developing healthy communication strategies, identifying codependency and boundary issues, and establishing mutual trust and respect help teens and young adults develop the skills needed as they navigate through life.

Healthy relationship education can also have a positive impact on families by teaching parents how to recognize the warning signs of abuse. "Though 82 percent of parents feel confident that they could recognize the signs if their child were experiencing dating abuse, 42 percent could not correctly

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[1] Perry, Bruce D. M.D., Ph.D. (1997). *Incubated in Terror: Neurodevelopment Factors in the 'Cycle of Violence.'* In: Children, Youth, and Violence: The Search for Solutions (J Osofsky, Ed.). Guilford Press, New York, pp 124-148.
[2] Centers for Disease Control and Prevention. (May 19, 2006). *Physical Dating Violence Among High School Students– United States, 2003.* Morbidity and Mortality Weekly Report. Vol. 55, No. 19, 532-535.
[3] U.S. Department of Justice, Bureau of Justice and Statistics. (Nov. 2012). *Intimate Partner Violence in the United States, 1993-2010.* Washington, D.C.

identify all the warning signs of abuse."[4] When we are intentional about learning and modeling healthy relationships, the entire family unit benefits. This intentionality creates an environment in the home where open and honest conversations can take place, especially about issues that are frequently shrouded in secrecy.

Arizona provides various healthy relationship programs to teens, families, and communities that address dating, sexual, and domestic violence. Protecting their Innocence, 101-401 by the Southwest Family Advocacy Center (www.swfac.org), Healthy Relationship Education by Arizona Youth Partnership (www.azyp.org), Safe Dates by Touchstone (www.touchstonehs.org), Safe Teens AZ through the Maricopa County Attorney's Office (www.safeteensaz.org/dating-violence), and Kaity's Way (www.kaitysway.org), are a few of the healthy relationship education programs found throughout Arizona. The Arizona Coalition to End Sexual and Domestic Violence (www.acesdv.org) provides numerous resources that promote public awareness through information, training, awareness campaigns, events, and the media.

When we take a proactive approach and intentionally educate our children, families, and communities about healthy relationships, we make a positive impact, enabling our children to be self-aware, compassionate, and healthy members of society.

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[4] Fifth & Pacific Companies, Inc. (Liz Claiborne, Inc.), Conducted by Teen Research Unlimited. (May 2009). *Teen Dating Abuse Report 2009: Impact of the Economy and Parent/Teen Dialogue on Dating Relationships and Abuse.*

EXPERIENCES THAT HELP FAMILIES THRIVE

By Eric Legg, Ph.D.
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with contributions from Dale Larsen, Cynthia Brown, Alex Laing,
Stacy Beadle, Wendy Resnick, Samantha Coffman, Leah Fregulia

Participation in social recreational activities like team sports and other group activities can help to promote the protective factor of social and emotional competence of children by promoting psychosocial adjustment and social skills. (For more information about protective factors see the Strengthening Families and Protective Factors chapter.)

Sports

Approximately 70 percent of youth in the United States participated in a team or individual sport in 2017, making youth sport a key area for potential youth development.[1] Existing research points towards a number of areas where sport participation can have positive benefits. Physically, youth sport participants generally have increased cardio and respiratory functions and increased flexibility and stamina compared to non-participants. In addition, youth sport participants are more likely to engage in healthy behaviors outside of sport (e.g. healthy eating) and less likely to engage in unhealthy behaviors (e.g. drug abuse) than non-participants. In addition to the physical benefits, youth participants may also benefit from increases in self-esteem, positive identity development, increased social relationships, and leadership and teamwork development.[2]

Sport Trends

Although traditional team sports (e.g. basketball, baseball, football, and soccer) continue to be popular, sports such as ice hockey, lacrosse, volleyball, and track and field are drawing an increasing number of participants. Based on the most recent data, baseball and basketball represent the most popular sports among children ages 6-12 with approximately 4 million participants nationwide in each sport. Soccer and tackle football experienced the most substantial declines in participation, witnessing approximately 10 percent drop in participation in the most recent year. In fact, for the first time, the number of youth flag football participants now exceeds the number of tackle football participants (with slightly less than 1 million youth participating in each).[3]

[1] Aspen Institute (2018). *State of Play 2018: Trends and Developments*. Retrieved from: https://assets.aspeninstitute.org/content/uploads/2018/10/StateofPlay2018_v4WEB_2-FINAL.pdf?_ga=2.227871069.1788462421.1545413940-204763750.1542138282
[2] Legg, E. (2018). *Community Recreation Programs*. In S.G. Arthur-Banning (Ed), Youth sports in America: The most important issues in youth sports today (pp. 92-100). Santa Barbara, CA: ABC-CLIO
[3] Search Institute. (n.d.). *Search Institute's Youth Development Research*. Retrieved from: https://www.search-institute.org/our-research/youth-development-research/USA Life Expectancy (2017, December 20).

Of particular concern to youth sport providers, participation rates based on household income continues to reflect the rising costs of youth sport. Only 34 percent of children in families making under $25,000 per year participate in youth sport, and that number steadily increases to nearly 70 percent of children in families making greater than $100,000.[4] These rates also correspond with physical activity, as children in families with lower incomes are the least physically active among all income groups. Rising costs are a result of both increased fees to participate (largely resulting from cuts to municipal funding), and also to an increased emphasis on more competitive opportunities, which often require additional funding for travel, equipment, and in some cases advanced coaching.[5]

Participation by gender has remained largely unchanged in the past seven years, with approximately 62 percent of male children participating in a team sport, and approximately 52 percent of female children participating.[6]

Context Matters

Though it is evident that participation in youth sport programs can lead to numerous positive benefits for youth, it is also important to note that participation does not automatically lead to benefits. The majority of youth sport coaches are volunteers, often with no experience or training in coaching or youth development principles. As such, even well-meaning coaches, often engage in behaviors that may not leverage youth sport to its maximum positive benefit. Similarly, news stories abound with stories of poor parent behavior. Poor coaching and negative parent behavior are a few of the reasons contributing to the high dropout rate in youth sport program, with approximately 70 percent of youth dropping out by the age of 13.[7] If youth sports are to be an environment for positive benefits, it is critical that the overall context of programs is addressed.

Parks and Recreation

Parks and recreation program exist within most Arizona municipal governments, and provide community programs for youth and adults, as well as parks, fields, and trail management and maintenance. In addition, nonprofit organizations such as the YMCA or Boys and Girls Clubs often offer similar programs.

From a facilities perspective, parks and recreation organizations provide community centers including programs that may be teen or senior specific, aquatic centers, parks, and sport facilities. These facilities offer a wide variety of programming for all ages, including senior adults, teens, elementary and pre-school, as well as specialty programs such as nature or art programs.

Teen Programs

Parks and recreation agencies also offer a number of programs geared specifically toward teens. Like

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[4] The Aspen institute. (2018). *State of Play 2018: Trends and Developments* (p. 5). Retrieved from: https://assets.aspeninstitute.org/content/uploads/2018/10/StateofPlay2018_v4WEB_2-FINAL.pdf?_ga=2.227871069.1788462421.1545413940-204763750.1542138282
[5] Ibid.
[6] Ibid.
[7] National Alliance for Youth Sports. (2015).

many parks and recreation services, teen programs experienced substantial cuts during the 2008 recession. However, today organizations are increasing teen offerings in a variety of areas. Teen programs range from after school programs to programs in youth development and leadership or STEM programs. For example, PHX Teens offers activities created by teens for teens, and Code PHX also offers coding, robotics, and 3D Modeling education for youth of all ages.[8] YMCAs also offer programs for teens with a focus on building self-esteem and self-confidence, learning healthy lifestyle choices in a safe, supportive and engaging environment.[9]

Nationally, teen programming is moving away from an "at-risk" model to a model focused on positive youth development (PYD). In traditional "at-risk" models, teen programming emphasize youth deficits and attempts to remedy those deficits. In contrast, a PYD model focuses on youth as resources to be developed, rather than problems to be solved. One popular model of positive youth development is Developmental Assets. Developmental Assets represent a list of 40 assets (20 internal and 20 external) that youth may have. A wide body of research suggests that the more of these assets a youth possesses, the more successful they will be in life. As such, a number of teen programs have begun to focus on building assets, rather than addressing problems.[10]

Elementary and Tot

Elementary and tot programs, most frequently in the form of after-school programs, represent a key part of the mission of parks and recreation. After-school programs (frequently referred to as "out of school" time) may be general in nature, offering a variety of activities on any given day, or specialized. While most elementary programs in parks and recreation as well as YMCAs and Boys and Girls Club present the more general model, private organizations and schools may provide specialized programs with an area focus such as science or art. Tot programs often include parents directly in the program. Families interested in finding options for elementary and tot programs can find online listings of many programs through Raising Arizona Kids (www.raisingarizonakids.com) or the Arizona Center for Afterschool Excellence (www.azafterschool.org).

Nature Programs

While parks and recreation programs are often organized around age groups, certain areas often offer programs across ages. One of the most common types of programs is nature programs. Nature programs frequently reside within a nature center and are generally operated by either a local or federal agency or a non-profit organization. For example, Willow Bend Environmental Education Center in Flagstaff, Arizona offers programs for elementary through college age, as well as programs specifically for teachers.[11] Programs cover a wide range of topics including geology, plant life, fire ecology, and indigenous cultures. Similarly, Maricopa County Parks and Recreation offers nature programs at Estrella Mountain Regional Program such as guided hikes, birdwatching, and mountain biking.[12]

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[8] Retrieved from: https://www.phoenix.gov/parks/teens
[9] Retrieved from: https://valleyymca.org/programs-activities/teens/
[10] Search Institute. (n.d.). Search Institute's Youth Development Research. Retrieved from: https://www.search-institute.org/our-research/youth-development-research/
[11] Retrieved from: https://willowbendcenter.org/
[12] Retrieved from: https://www.maricopacountyparks.net/park-locator/estrella-mountain-regional-park/

Aquatics Programs

Aquatics programs are offered through municipal parks and recreation agencies, non-profit organizations (primarily the YMCA), as well as for-profit providers. Though aquatics programs may include swim teams and master's swimming programs, the most common aquatics programs are learn to swim programs. Arizona ranks as one of the worst states for drowning deaths, and thus learn to swim programs represent an especially important program for children and families. As with many recreation programs, many aquatics programs as well as open swim hours were cut during the 2008 recession.[13] However, most municipalities continue to offer learn to swim programs from ages 6 months through adults. Most programs occur daily for approximately 30 minutes over a two-week period. Swim lessons often follow nationally established lesson plans including Red Cross programs and Starfish learn to swim.[14,15]

Special Events

It is also worth mentioning that parks and recreation agencies are often the organizers of community special events. Special events range from outdoor movie nights to larger events such as Fourth of July festivals or the Thunder Valley Rally in Arizona.

Libraries

Though libraries are most often associated with providing books, they also provide a wide variety of community services. Libraries help address literacy, school readiness, the digital divide, and out-of-school enrichment. Statewide, there are over 200 public libraries.[16] Library programs serving children and families generally fall into one of four categories: school readiness, out-of-school enrichment, teens – civic engagement, workforce literacy and volunteerism, and teens – college access. Each of these is outlined below.

School Readiness

The bread and butter of library programming is storytime. Thousands of children participate every week in carefully constructed early literacy programs that are not only entertaining, but provide modeling for parents on how to develop pre-reading skills at home. Phoenix Public Library, for example, offers approximately 80 separate programs for babies, toddlers and preschoolers every week.[17] Some programs also incorporate sign language as a great way to speed language development in pre-verbal children.

Phoenix Public Library offers Kindergarten Bootcamp, which is a seven-week program for children about to enter kindergarten.[18] In Bootcamp, parents learn what skills children need to be successful in school and easy ways to develop those skills in the months before school begins. The program is modeled on

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[13] USA Life Expectancy. (2017, December 20). *USA Drownings Death Rate By State.* Retrieved January 4, 2019 from; https://www.worldlifeexpectancy.com/usa/cause-of-death/drownings/by-state/

[14] Retrieved from: https://www.redcross.org/take-a-class/swimming/swim-lessons/kids-swim-lessons

[15] Retrieved from: http://starfishswimschool.com.au/

[16] Retrieved from: https://publiclibraries.com/state/arizona/

[17] Retrieved from: https://www.phoenixpubliclibrary.org/

[18] Phoenix Public Library. (n.d.). *Kindergarten Bootcamp.* Retrieved January 7, 2019 from: https://www.phoenixpubliclibrary.org/kids/Pages/Kids Programs/Kindergarten-Bootcamp.aspx

Arizona Early Learning Standards, as well as the College and Career Standards for kindergarten. More than 2,000 children have "graduated" from Bootcamp over the last three years.

Out-of-school Enrichment

From book clubs to makerspaces, Arizona libraries provide engaging and educational learning opportunities for school-age children. Summer reading is a universal public library offering that attempts to keep children reading during the summer break. It's especially important for beginning readers, so they don't lose the fluency and decoding skills they've learned in school. It's widely recognized that this "summer slide" disproportionately affects children from low-income households and contributes to lower than average third grade reading proficiency scores.[19] Maricopa County Library District developed an online summer reading program (with support from the Arizona State Library) that supports summer reading success for all residents of Maricopa County. Science, Technology, Engineering, Art and Math, or STEM programs, are also popular in libraries. Making slime, building with Lego® blocks, designing robots and catapults provides fun, hands-on learning.

Libraries may also assist in addressing basic needs of youth. For example, Kid's Café is a nutrition and education program provided in partnership with St. Mary's Food Bank that provides free meals to children at six libraries during the school year (expands to eight libraries during summer). During the meal service, a variety of educational activities are provided.

Teens - Civic Engagement, workforce literacy & volunteerism

Libraries often offer dedicated spaces, computers and collections for teens. Burton Barr Central Library in Phoenix, for example, provides 5,000 square feet of dedicated space for a teen library called Teen Central. While there are entertaining programs for teens, such as movie nights and video gaming, libraries also offer teens a chance to learn and grow. From poetry slams to resume writing, teens have an opportunity to explore their interests and acquire new skills. Volunteering in libraries is also a way that many teens learn valuable job skills. Every summer, Phoenix Public Library engages 300-400 teens as volunteers.

Teens - College Access

Libraries also serve as a valuable source for college preparation. College Depot is a free, full-service college access center located at the Burton Barr Central Library in Phoenix. College Depot staff provide assistance with college planning, college applications, financial aid, scholarship searches, ACT/SAT test results interpretation, and much more. Most of College Depot's patrons are low-income and 45 percent speak Spanish at home. Middle school students, high school students, and adults all use their services, sometimes from the same family.

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[19] Smith, L. (2011-2012). *Slowing the Summer Slide*. Educational Leadership, 69(4), 60-63. Retrieved January 7, 2019 from: http://www.ascd.org/publications/educational-leadership/dec11/vol69/num04/Slowing-the-Summer-Slide.aspx

[20] Arizona Commission on the Arts. (2016). *Strengthening Schools Through Arts Partnerships Evaluation Summary: First Cohort, 2013-2015*. Retrieved from: https://azarts.gov/grant/strengthening-schools-through-arts-partnerships/

Fine and Performing Arts

Fine and performing arts programs are often offered through schools. However, approximately 35 percent of K-8 students lack access to arts and music.[20] Thus, private nonprofit programs offer an important bridge to fill the gap between school programming and arts access. Prominent organizations offering arts programming include Phoenix Center for the Arts, Rosy House, Phoenix Conservatory of Music, Rosie's House, and Harmony Project. Phoenix Center for the Arts programs include both summer camps as well as camps throughout the year during school breaks, festivals, and mobile arts programs. Rosie's House is a community music school with a focus on children from economically challenged backgrounds, and includes musical instrument lessons, choir, and a college readiness program. For theater options, organizations such as Rising Youth Theater, Valley Youth Theater, Spotlight Youth Theater, Actors Youth Theater, offer opportunities for youth in the Phoenix area to participate in live theater through live shows as well as camps and classes. The focus of Act One is to provide arts experiences to those who otherwise could not afford it. To fill this mission, Act One provides field trips to arts performances to youth in Title One Schools. In addition, Act One sponsors the Culture Pass. The Culture Pass is available in libraries and offers free access to cultural attractions throughout Arizona.

GOVERNOR'S OFFICE PERSPECTIVE ON FAITH COMMUNITIES

Arizona Governor's Office of Youth Faith and Families

A Crucial Link to Family Well-Being

Throughout the world, temples, churches, mosques, synagogues, and religious communities help support and strengthen the well-being of families. Faith communities provide critical support and serve families in the areas of health care, education, economic stability, social justice, and spiritual development, often in close collaboration with civil society and governmental agencies.[1] While the United States upholds the separation of church and state, numerous and varied opportunities exist for intentional and effective partnerships between public, private, non-governmental agencies and faith communities.

Faith as a Protective Factor

It is estimated that over 5.8 billion adults and children in the world adhere to a religion.[2] Over 70 percent of adults in Arizona have a religious affiliation.[3] Research shows that religious affiliation and belonging to a faith community can mitigate the effects of trauma experienced by the adherents. Positive religious coping has been associated with decreased psychological distress in survivors of child abuse, sexual violence, intimate partner violence, community violence, and war.[4]

The Center for the Study of Social Politics' Strengthening Families (CSSP-SF) is a research-informed approach to increase family strengths through the development and cultivation of protective factors. These protective factors are recognized as, "characteristics or strengths of individuals, families, communities or societies that act to mitigate risks and promote positive well-being and healthy development."[5] Five key protective factors can be cultivated and reinforced as a result of belonging to, or being supported by, a faith community. The protective factors are parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. (See Strengthening Families and Protective Factors chapter for more details on the protective factors.)

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[1] Hammer, S., Greenberg, A., Keshavarian, G. (2009). *Religious Communities Take the Lead for Children*. Dharma World Magazine. Quarterly, 2009, Vol. 36, April-June 2009.

[2] Bryant-Davis, T. Wong, E.C. (2013). *Faith to Move Mountains: Religious Coping, Spirituality, and Interpersonal Trauma Recovery*. American Psychologist, Vol. 68, pp. 675-684.

[3] Pew Research. (2018). *Religious Landscape Study*. Retrieved from: http://www.pewforum.org/religious-landscape-study/state/arizona/

[4] Bryant-Davis, T. Wong, E.C. (2013). *Faith to Move Mountains: Religious Coping, Spirituality, and Interpersonal Trauma Recovery*. American Psychologist, Vol. 68, pp. 675-684.

[5] Center for the Study of Social Politics. (n.d.) *Strengthening Families Increasing Positive Outcomes for Children and Families*. Retrieved from: https://cssp.org/

Supporting Families

Military Families

Collectively, the military personnel of the Department of Defense, Active Duty, National Guard and Selected Reserve is approximately 2.25 million in the U.S. There are an additional 3.13 million family members who are impacted by their loved one's service.[6] Arizona is home to over 600,000 service members, veterans and their families. Faith communities have been meeting the needs of military families in America for more than a century. The Continental Congress established the military chaplaincy on July 29, 1775. The Chaplain Corps has grown to almost 3,000 chaplains representing more than 130 different faiths and denominations. Chaplains offer spiritual support to military members of all faiths and their families.

Active duty military families greatly benefit from this type of societal support due to chronic relocation, parental deployment, living in war-impacted communities, and combat-related trauma. Faith communities are able to minister to these needs by creating support groups, assisting with child care, praying for and sending care packages to deployed members, providing safe and caring environments for spiritual growth and healing, and collaborating with other agencies to provide wrap-around care. Christ Community Church in Tucson serves active duty members and their families from local Air Force and Army bases, Air National Guard, University of Arizona ROTC programs, and other local Reserve bases. They also have veterans on staff and as members on their elder board. Congregations are able to meet the social and communal needs of military families.

Veterans also have unique needs. Due to the realities of war and military life, many veterans struggle with finding housing and employment, getting health care, and re-entering civilian life. These challenges can lead to family separation, homelessness, and financial and food insecurity. They can also lead to or exacerbate mental health issues. In the U.S., more than 6,000 Veterans committed suicide each year from 2008-2016.[7] In 2016, 227 veterans in Arizona committed suicide.[8] Research shows that spirituality can improve post-trauma outcomes in veterans by mitigating their impact.[9] Faith communities help veterans by providing information and referral services, spiritual counseling, financial and nutrition assistance, and social support. The Arizona Coalition for Military Families partners with faith communities across the state and provides resource navigator trainings and informs clergy on best practices for serving military families and veterans.

Families with Disabled Children

Developing supportive social networks and providing hope and optimism during adversity are functions of faith communities that especially benefit people with disabilities and their loved ones. For example, the frequency of attendance to religious services for children with special needs was found to be

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[6] Military Family Research Institute at Purdue University. (n.d.). *How to Help Series*. Retrieved from: https://www.mfri.purdue.edu/resources-and-research/how-to-help-series/

[7] U.S. Department of Veteran Affairs. (2018). *VA National Suicide Data Report 2005-2016. s.l.* Office of Mental Health and Suicide Prevention.

[8] U.S. Department of Veteran Affairs. (2016). *Arizona Veteran Suicide Data Sheet 2016. s.l.* Office of Mental Health and Suicide Prevention.

[9] Military Family Research Institute at Purdue University. (n.d.). How to Help Series. Retrieved from: https://www.mfri.purdue.edu/resources-and-research/how-to-help-series/

positively correlated with their parents' rating of family life. Being better able to cope with the day-to-day demands of raising children with special needs was included in the list of positive outcomes for these families. Parents of children with special needs who experienced love and acceptance reported their congregations were sources of great strength and support.[10]

Beth Tefillah, a Jewish congregation in Scottsdale, Arizona, supports their members with special needs and their families in various ways. They offer inclusion support, community education and training, social groups for children and adults, a monthly inclusionary service, sign language interpreters for community events and religious services, and adult residential support.[11] Scottsdale Bible Church's Special Ministries provide safe place for more than 100 of their members with special needs to worship together and build community.[12] They have classes for adults and children with disabilities twice a week at their Shea campus.

Families in Crisis

Families Experiencing Homelessness

According to the U.S. Department of Housing and Urban Development, 554,000 people in the nation were homeless in 2017. Based on reports from Maricopa, Pima, and rural counties in 2017, Arizona's homeless population was estimated to be over 37,000. Almost two-thirds (59 percent) were in Maricopa County. Faith communities have been consistent in addressing homelessness throughout history. Caring for vulnerable and homeless populations is a universal mission for faith communities and faith-based organizations (FBOs) around the world.

Almost 30 percent of homeless people in Maricopa County are families, mostly single mothers with children.[13] In 2017, the Phoenix/Mesa metro area ranked in the top ten cities for highest number of homeless individuals and families in the U.S.[14] Due to the domino effect of homelessness, families need stabilizing resources and services that assist with housing, employment, childcare, transportation, parenting and education. Several FBOs and local congregations have established programs to prevent and reduce homelessness in Arizona. One example is the Phoenix Rescue Mission, located in downtown Phoenix. They operate several programs that serve the hungry and the homeless, providing food, lodging, substance abuse treatment, social support, and spiritual transformation. Their Changing Lives Center for Women and Children is the only faith-based recovery program in the region that offers long-term, comprehensive services to women and children.[15]

Families Impacted by Substance Use

Substance abuse continues to have an adverse and lasting impact in the lives children and families nationwide. Recently, the opioid epidemic in the U.S. has spurred government and civil leaders to action.

[10] Religioninsights.org. (2018). *7 Ways Congregations Can Embrace People with Special Needs*. Insights into Religion.

[11] Beth Tefillah. (2018). *Gesher Disability Resources*. Retrieved from: bethtefillahaz.org

[12] Scottsdale Bible Church. Special Ministries. Retrieved from: scottsdalebible.com

[13] Trailor, M. (2017). *Homelessness in Arizona Annual Report 2017*. Phoenix : Homeless Coordination Office Arizona Department of Economic Security Division of Aging and Adult Services.

[14] Henry, M., Watt, R., Rosenthal, L., and Shivji, A. (2017). *The 2017 Annual Homeless Assessment Report to Congress. s.l.* U.S. Department of Housing and Urban Development Office of Community Planning and Development.

[15] The Phoenix Rescue Mission. *Homelessness*. Retrieved from: https://phoenixrescuemission.org/homelessness/

In Arizona, Governor Doug Ducey, with unanimous support, signed the Arizona Opioid Epidemic Act into effect, designating $10 million for addiction treatment and setting a notable example for other states. Governor Ducey supports partnerships with the faith community in addressing many of the state's social issues.[16] Several Arizona FBOs, along with other community organizations, have been resourced to provide opioid prevention and treatment programs.

According to the Substance Abuse and Mental Health Services Administration, faith is a key component to coping and recovery. There are several ways in which faith communities serve families impacted by substance use. Many local congregations open their sanctuaries and meeting rooms to the public for substance use recovery support groups. Approximately 70 churches in Arizona host Celebrate Recovery groups, a faith-based 12 step program. Through a partnership with the Arizona Governor's Office of Youth, Faith and Family, Terros Health and Sonoran Prevention Works, Celebrate Recovery regional leaders across the state were trained and equipped with naloxone, an opioid overdose reversal medication.

Families in the Child Welfare System

There is a strong, positive relationship between child welfare and religion. Compassion for children and a commitment to family life are common ground between the faith community and professionals concerned about the well-being of children.[17] Taking responsibility for one another and caring about their neighbors is a hallmark of many faith communities' beliefs and value systems. Therefore, their mission inherently calls them to improve the quality of life for families and children.[18] In recent years, child welfare agencies and coalitions have published guides and tool kits that outline best practices for collaborating with faith partners. In their guide, *Finding Common Ground: A Guide for Child Welfare Agencies Working with Communities of Faith*, AdoptUSKids highlights ways in which communities of faith play a significant role in human services and offers 12 partnership practice principles for agencies and systems to strengthen their collaborations with the faith community.

In 2017, the U.S. had over 440,000 children in foster care, with almost 270,000 entering and more than 247,000 exiting care.[19] In part, through collaboration with the faith community, Arizona has seen a decrease of 16 percent in the number of children and youth in out-of-home care (from 16,700 in 2017 to 14,059 as of November 2018).[20] The vast majority of children and youth in out-of-home care in Arizona reside in family-home settings (38 percent with relatives/kin and 42 percent in licensed family foster homes). Arizona's Faith communities and FBOs combine resources to ensure children are placed in safe and nurturing environments - foster or adoptive. Arizona 1.27, an interfaith initiative emerged to encourage and support foster and adoptive parenting, exemplifies such collaboration. The organization provides statewide trauma-informed training and technical assistance to lay people to help them develop and sustain ministries that provide specialized care for foster and adoptive families. Currently ninety churches in Arizona are affiliates of Arizona 1.27.

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[16] Kennedy, N. (August, 2018). *Most Recent*. Retrieved from: http://www.sharedjustice.org/most-recent/2018/8/13/the-faith-community-in-action-a-response-to-the-opioid-crisis

[17] Mikula, G. R., Anderson, J. (2012). *Spirituality and Religion in Child Welfare Practice*. Retrieved from: nacsw.org/Download/CSW/ChildWelfare.pdf

[18] Cipriani, M. J., Henneman, K., McKenzie, J.K. (2012). *Resources*. Retrieved from: http://www.adoptuskids.org/_assets/files/NRCRRFAP/resources/finding-common-ground.pdf

[19] U.S. Department of Health and Human Services, Administration for Children and Families. (2018). *AFCARS Report #25*. Retrieved from: https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf

[20] Arizona Department of Child Safety. (Dec., 2018). *Department of Child Safety - Monthly Operational Report_Dec 2018*.

Families involved with the child welfare system also benefit from established agencies that have offered comprehensive services for decades. Local and national FBOs such as Catholic Charities, Jewish Family & Children Services, Christian Family Care, and Harvest of Hope operate programs in Arizona that support families with varying levels of child welfare involvement. Contracted with the Arizona Department of Child Safety, these organizations provide group homes, access to foster and adoptive families, family preservation, counseling, therapy, and behavioral health services with the goal of keeping families together.

CarePortal

Faith communities have proven to be dynamic and essential partners for families at risk of entering the child welfare system. Nationally, 1,735 churches partnering with CarePortal have served 33,336 children in eighteen states, to date.[21] By partnering with CarePortal, congregations have an opportunity to serve at least one of ten purposes that support the well-being of children and families. Those purposes include strengthening biological families, preventing foster care entry, reunifying families, supporting or preserving foster, kinship, or adoptive placement and supporting transitioning youth.

 In Arizona, the CarePortal Project is a partnership between the DCS, CarePortal and FBOs. CarePortal equips caseworkers at DCS with a network of local congregations through a communications platform that allows case workers to notify partnering churches of a family's specific need. Congregations then identify members who are able and willing to assist the family. The needs of the families can vary; and whether it's a request for baby items or home repairs, the faith community responds to the call.

Arizona faith communities that partner with CarePortal are bridging gaps to help families comply with DCS standards of safety to prevent children from entering the foster care system. From inception to December 2019, 4,409 children have been served through CarePortal in Arizona with an estimated economic impact of $1,561,011. Currently, 113 churches are participating in the Arizona counties of Pima, Maricopa, and Yuma (with plans for additional expansion in 2019).

Arizona Trauma-Informed Congregation Movement

Adverse Childhood Experiences (ACEs) and trauma are common and impact people in American communities regardless of socioeconomic status, ethnicity, age, or gender. Arizona holds the less-than-distinguished honor of leading the nation in the percentage of children who have experienced between 3-8 ACEs.[22] SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[23] Health care providers, educators, business professionals, and government officials are all becoming more aware of and sensitive to the widespread effects of trauma on society and daily life.

With the increased awareness of trauma and its impact on individuals, families, and communities, the faith communities in Arizona are collaborating to inform and train clergy and lay people on identifying,

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[21] Arizona Department of Child Safety. (Dec., 2018). *Department of Child Safety - Monthly Operational Report_Dec 2018*.
[22] CarePortal. (n.d.). *Home. Careportal.org*. Retrieved from: https://careportal.org/
[23] Substance Abuse and Mental Health Administration. (n.d.). *Trauma & Violence*. Retrieved from: https://www.samhsa.gov/trauma-violence

addressing, and preventing trauma in their congregations. Pastor Sanghoon Yoo of the Faithful City is leading the effort with the Arizona Trauma Informed Faith Community. Pastor Yoo, through collaboration with the Arizona ACE Consortium, has rallied several congregations across the state, creating regional trauma-informed congregation leaders. These leaders champion the movement and recruit clergy and congregations in their area, and train, equip, and support them in becoming trauma-informed ministries. There are monthly meetings and trainings held in each region that members can attend to stay up to date on key issues related to trauma and ACEs, network with other trauma-informed congregations and receive on-going support. As this movement gains ground, many families in Arizona will be better supported by their faith communities.

Governor's Office of Youth Faith and Families

Communities can benefit from better coordinated supports when federal, state, and local agencies recognize the value in creating sustainable partnerships with faith communities and FBOs. In Arizona, these partnerships aim to improve the quality of life for all Arizonans - especially the most vulnerable. In recognition of the important link between family well-being and the faith community, the Council on Child Safety and Family Empowerment (CSFE) was authorized under Executive Order 2015-08.[24] Staffed by the Governor's Office of Youth, Faith and Family, the Council consists of 29 members appointed by the Governor and is chaired by First Lady Angela Ducey. The Council's mission is to align, leverage, and coordinate faith-based and community resources to address challenges faced by vulnerable children and families within the child welfare system. In addition, the Council provides additional supports to strengthen families that are caring for both foster and adopted children.

From 2015 to 2018, the Council on Child Safety and Family Empowerment has born witness to the excellence and dedication of Arizona's faith communities and FBOs in their provision of prosocial support, services, and resources for all families; including families with special needs or those that are in crisis. Faith communities and FBOs are invaluable partners in bolstering family well-being through their involvement and advocacy in social issues such as substance abuse, homelessness, and child welfare.

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[24] Office of the Arizona Governor, Doug Ducey. (2019). Council on Child Safety and Family Empowerment. Governor's Office of Youth, Faith and Family. Retrieved from: http://faithandcommunity.az.gov/faith-and-community/faith-and-community/council-child-safety-and-family-empowerment

By Virginia Watahomigie, M.ADM
Executive Director, Coconino Coalition for Children & Youth

Nonprofits

Arizona nonprofit agencies play a crucial and cost-effective role in the state's prevention strategies and response to child welfare issues. Generally, missions of nonprofit agencies are geared toward meeting the long-term needs of our children and families, making nonprofits a strong defense and response system for the needs of our communities.

Nonprofits Expand Financial Capacity of Communities

Nonprofits are often engaged in multiple fundraising avenues including seeking grants and donors, thereby allowing them to expand their financial resources from the State beyond the bounds of the annual general fund allotment for services. The increase of funding to services through fundraising of nonprofit agencies is tremendous. For example, there have been drives for homeless and runaway youth in Northern Arizona, donations for pajamas and holiday parties for foster families in Southern Arizona, and the influx of large federal grants for programming across the state.

Nonprofits Expand Social Capital of Communities

Nonprofits are committed to change and engage in community outreach and because of this, they attract volunteers, supporters and community members who are interested in banding together to provide support for the needs of our communities. The collective impact of nonprofits and individuals banding together in a cause exemplifies and showcases the magnitude of response that is possible when varied groups come together. The nature and missions of nonprofits become natural lightning rods to attract the support of various members of the community toward a cause.

Nonprofits Expand Service Availability and Accessibility for Communities

Crucial services such as Parent Aid, Foster Care Recruitment and Supervision, Shelter Services and In-

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WORKING TOGETHER

The Foster and Adoptive Council of Tucson worked together to support a strong recruitment and retention strategy for foster families in Pima County by:

- Creating a strong informational presentation

- Monthly orientations with agencies taking turns giving the presentation and all agencies presenting to answer questions, allowing a one-stop for interested families

- Marketing and advertising of orientation events

- Planned retention strategies such as Foster Care Appreciation Events and "Blue Ribbon" Campaigns

- Referrals among agencies to support best fit of services based on client need

- Support and coordination for drives and giveaways to support families

home services are provided by nonprofit agencies throughout the State. For example, these programs provide:

- Supervised family visitations that are required when a child is removed
- Connections to foster families for placement of children in unsafe situations
- Shelter for a parent removing him or herself from a domestic violence situation
- In-home therapy and counseling needed to help families heal while allowing children to remain with family

These nonprofits work hard to meet the challenges of providing quality services, meeting regional demands and develop solutions to counteract the numerous challenges that may be faced.

Many non-profits that don't have contracts with the State of Arizona still provide support to families in ways that support the state as a whole. Some of the services these non-profits provide address families' basic needs such as clothing, food and utility support funds. Communities are benefitting tremendously when programs are lifting individuals up through meeting various needs.

Submitted by Arizona's Children Association
A father was referred for Parent Aide Services in September of 2017. As a young parent and having little engagement with his child, he expressed concern and an overall lack of self-confidence in his ability to parent a young child, but consistently expressed his love and care for his daughter. He was actively involved in services from the beginning and worked hard to engage positively with his daughter's current placement, her maternal grandmother, who had been her consistent caregiver for most of her young life. He expressed his overall satisfaction and gratitude for having the opportunity to engage in Parent Aide Services, citing the skills sessions as providing the support he needed to gain confidence in his ability to build a meaningful relationship with his daughter. This is a story of success, where a young child was able to maintain a permanent home with the caregiver she has always known, while still having regular contact with her father who is now a consistent, supportive adult in her life.

Nonprofits Facilitate Collective Impact and Best Practice Adoption

Arizona benefits by having nonprofits committed to best practice, quality programs, ongoing staff development and long-term strategies to promote healing, sustainability and support to our communities (combined with the nonprofit agency's ability to raise funds for these high-quality programs).

Additionally, nonprofits are integral in creating systems of collective impact where many different non-profits come together and pool their resources and capacity to extend the reach and services available to a given population. For example, in Southern Arizona, Foster and Adoptive Council of Tucson (FACT) was instrumental in creating recruitment and retention strategies for foster and adoptive families. This collaborative approach expanded the abilities, reach, scope and sophistication of strategies to meet the need compared to what any one agency could have done on their own.

Northern Arizona has the Coconino Coalition for Children & Youth (CCC&Y). Through cooperation and targeted strategies, non-profits, governmental entities and businesses are working together in this group to impact the prevention of child abuse and community response to trauma.

One success the CCC&Y realized was bringing Kevin Campbell, an internationally known child welfare expert, to Northern Arizona in 2017 for a project related to family finding and "changing casework

as usual." Mr. Campbell provided coaching and high-level training focused on creating a culture shift towards best practice work among the staff of nonprofit agencies and systems in Coconino County. This approach had been tried in the past but the effectiveness was limited to individuals that received training within their nonprofit, and did not extend to any outside partners. The Kevin Campbell project in Northern Arizona was different as the goal was to train as many agencies and personnel as possible across the county. Child welfare operates on a system of teams for the child (case managers, behavioral health, education, community, etc.). The level of coordination achieved on the Kevin Campbell project would not have been possible without the tremendous support and cooperation of numerous nonprofit partners.

Many Challenges Threaten Nonprofits

Frequent Changes in Mandates to Nonprofits Causes Inefficiency and Instability

A large challenge for nonprofits is the shift in goals, services or outcomes that happen frequently, sometimes suddenly, and often with little input of the affected nonprofits. Nonprofits often work diligently, and at much cost to recruit, train, develop and monitor their teams. They often make technological investments that allow for data and outcome collection. They create policies and systems to support the best practice and meet contractual requirements. When there are large shifts, newly created policies and systems often have to be scrapped and restarted at large costs in terms of dollars and time.

For example, after the recession, nonprofits that provided visitation services for parents with children in out-of-home care (a required service by law) stopped receiving referrals from the state. These non-profits had just recently started this contract and had large and new teams. The lack of referrals resulted in massive layoffs across the state. However, because it is a required service, nonprofits were shortly thereafter instructed to rehire so that referrals could once again resume.

Anyone who is responsible for managing staff members understands how draining a problem like this is to an entire system. Aside from the personal toll this took on the workers and families, the cost to nonprofits was tremendous.

Cost Savings Mindset Threatens Quality and Innovation

The current focus on cost savings in Arizona over quality is another challenge for nonprofits. Many non-profits struggle to provide needed services for their current contracts with the state, but at the same time see how much services could improve if stakeholders were willing to invest in quality services.

This lack of investment requires nonprofits to make difficult decisions that can impact quality. Yet, many nonprofits choose to invest in quality, regardless of difficulties. These investments are evidenced by staff credentials, training, ongoing development, and going above and beyond basic contractual requirements. Nonprofits focused on quality are able to maximize opportunities by working together to provide the highest level of service possible. If given additional funds, these high quality nonprofits could be trusted to do more and create even better outcomes.

Conversely, many nonprofits have noticed that some of their peer agencies do not meet the same high-quality standards. For example, when nonprofits do not invest in recruiting, hiring and developing

a high-quality work force they create teams of individuals who lack needed skills and knowledge to perform their jobs. A lack of knowledgeable and skilled workers limits a family's ability to achieve positive outcomes. For example, it is crucial that staff have a solid understanding of human development to identify abuse and trauma and effectively promote and monitor the highest quality of care for children. Unfortunately, quality nonprofits and nonprofits meeting minimum standards work on the same state contracts because there is an emphasis on cost over a nonprofit's quality and level of service.

Conclusion

Nonprofits provide much needed services to the state and they expand the dollars available to provide these services through their fundraising efforts. Careful, fully informed decisions are important prior to changing policies because nonprofit agencies will invest significant resources to make any new process function well.

Sometimes change is necessary, especially as new advancements are made, and it is important to seek nonprofit input prior to making changes. Nonprofits have valuable information both in terms of best practice, what is already being done, what is possible, and the cost to do business. It is also crucial to make "quality" a guiding value. There is ample evidence that shows us clearly the cost to society (homelessness, incarceration, mental and physical health concerns) when we do not safely and appropriately meet the needs of children and youth. The impacts of our decisions today have generational consequences for decades to come. While it is important to save on costs wherever possible, it is important to consider other guiding values.

This is an exciting time in Arizona because we are learning how to be a trauma informed state, we are reducing our numbers of foster children and we are assessing how to best provide child abuse and neglect prevention services, which will offer long-term savings. As we move forward with these exciting changes, we must remember that nonprofits, especially when supported through proper policy and practice, are an invaluable part of a strong, cost-effective, and outcome driven system of child welfare.

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